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Journal of SOCIAL HYGIENE

vol. 38

January 1952

no. 1



JAN 23 1952

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About our cover . . .

Captain Sylvester Lee and his family on their way to church in Tokyo. Tenth of a series of Journal covers on family life . . . photograph courtesy U. S. Army.

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THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association. Subscription price: \$3.00 per year. Single copy: 35¢.



Battle Field . . . Blood Bank

Five people stand in a blood bank line.

Bill, in uniform, straight from Korea. He is living today because the blood of someone else is flowing in his veins.

Mollie, young and earnest, a real doll. She wants her blood set aside for the personal use of her fighting boy friend, should he need it.

Sam, burly defense worker, bond buyer and veteran blood donor. He boasts that one corpuscle of his good red "burgundy" will keep a man alive indefinitely.

Robert Smith, portly, pin-striped symbol of respectability. He gives his office workers time off with pay to go to the blood donor center.

Donna Kane, housewife, mother of two GIs. She says very simply, "It makes me feel better."

Patriots all, they know their share is an important one, but trifling compared to the all-out sacrifice of the fighting man. What they don't consciously realize is that by living clean lives, they are able to give **good** blood, blood that can be used to vitalize the wounded. As good citizens, as worthy family members, as donors, they are able, too, to contribute toward that way of life that the GI is fighting for, and that he hopes to come back to someday.

America's fighting strength and America's future are **safe** in their hands.

TOMS RIVER LOOKS BACK — 1951-1941

A Family Relationships Course in Perspective

by Elizabeth S. Force

Ten years have passed since the Family Relationships course was introduced in Toms River High School. During that time slightly fewer than 1,000 junior and senior boys and girls have "taken" Family Relationships.

It would be gratifying to be able to say that as a result of this addition to the curriculum all sin, divorce, broken homes, marital unhappiness and mental suffering have been banished from Toms River and particularly from the lives of those happy few who together diligently considered ways and means of establishing strong, united, happier homes. Obviously we are able to make no such extravagant claims. Even modest claims are difficult to substantiate, although with a clear conscience we can *claim* more than we can *prove*.

The assumptions upon which the course were originally based were simple:

- Young people prepare themselves for all kinds of vocations by study, observation, experience, practice.
- Establishing a home and rearing children are the most vital of all vocations.
- Almost all boys and girls in the school eventually marry, establish homes and rear children.
- By study, observation and experience a certain amount of valuable learning can take place that will help them to do both jobs at least a little better than they might without any special training. We were certain the school could help them *a little . . .* we *knew* we could not do it *all alone!*
- We agreed with the writer who stated, "We will never have a much better world until we have happier marriages, happier homes, happier and more emotionally stable children."

Subversive Propaganda

We blithely disregarded four sinister and subversive rumors to the effect

- That boys and girls of 16, 17 and 18 were already "jelled" and inflexible, with habit patterns so rigid that changes in attitudes, points of view and behavior were unlikely to take place in any significant measure; therefore

- That by the time these young people reached their late teens our meager, well-intentioned offerings would prove to be more than likely too little and too late.

- That, anyhow, attitudes, ideals and ideas concerning love, marriage and parenthood were not *taught* but *caught*.

- That family life and sex life were practically synonymous.

We proceeded on the convictions

- That growth and learning are inevitable and continuous processes.

- That *no* learning can come too late, no matter how little there is of it.

- That in any event the thing was worth a try. What was there to lose?

What It's All About

Our concept of what Family Relationships was all about was perhaps naive, but firmly held.

- We held that Family Relationships was pretty much an “above the belt” matter.

- That what happened *in* and *to* the heart and head (emotions and intellect) mattered more than what happened *in* and *to* the pelvic region.

- That the three areas were without doubt interrelated.

- That sex education was really *character* education.

At once then the course leaned *away* from the emphasis on sex (as the word was then understood by the general public) and leaned instead *toward* the personal relationships and mental hygiene aspects of family living.

*The community
was a friend
to the school.*



There is little doubt that this choice of emphasis or slant saved us from some community censure, misunderstanding and perhaps eventual conflict. Our school system was on good terms with the community. We therefore proceeded on the belief that it was a *wise* (not an “ornery”)

community that kept its finger in the school curriculum pie. We were happy to work within the framework provided for us, a framework that permitted ample freedom and imposed no crippling limitations.

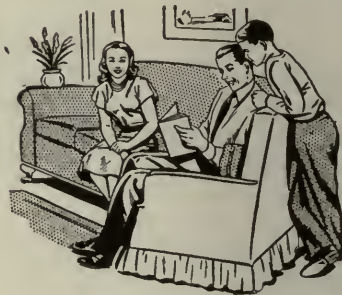
They Knew They Had a Good School

The excellent community-school relations were not an accident. A dynamic, creative leader, backed by a gifted and far-seeing Board of Education, had already upon several occasions demonstrated to the town fathers and mothers the value of other hitherto untried educational ventures. The taxpayers philosophically gave us the green light to go ahead with our newest notion. There was no mass meeting, no committee of representatives from organizations, no fuss nor fanfare.

It was really quite simple. The people knew they had a good school. They knew the school had an able leader and a reliable Board. They respected the faculty and trusted the educators to "do their stuff." In other words, past school performance had won confidence and goodwill.

A successful start was essential if the course was to click. We could not risk having it blow up in our faces. We were willing to go slowly, respecting the problem that was involved in handling in a public school situation so personal and delicate a topic as the family, which to each student immediately became (unconsciously) *my* family. New trails had to be blazed. Discretion and conservatism were the watchwords. Confidence had to be maintained.

*"Home work" —
the whole family
discusses
class problems.*



Interpretation had to be made so that when the family gathered around the supper table at night the ideas gathered through class discussion would be relayed with reasonable accuracy. To this end, problems that could be shared with friends and family were selected for discussion.

Reading matter was carefully screened and chosen so that it too could be safely shared with others who were not so close to the course.

Let the Community In

Community interest in the newfangled course ran high. Civic groups, service clubs and all types of organizations clamored for a speaker who could give them "the lowdown." The teacher and the principal addressed many such groups. Question periods at the end of the sessions provided a clearing-house for further exchange of ideas.

Whenever a group of Family Relationships pupils accompanied the speaker, they were royally received. Their candid views and challenging remarks amazed and delighted the adults. Even the most hidebound Three-R devotee could not refrain from responding to the sincerity, spontaneity and eagerness of the glowing young adults who in no uncertain terms spoke their minds on family and personal issues that affected them. No punches were pulled on either side. Mutual respect increased as a result of these meetings, for the young people too were impressed with the attitude of the adults.

"I didn't know that parents could be so intelligent!" remarked one astonished youth after one stimulating session.

The Aims Are Understandable

In establishing any course, and particularly this kind that reaches into the very heart of the home with its promises and its threats, it is necessary to have reasonable and acceptable goals. The goals must be expressed in language free from the pedagogical hocus-pocus that almost always throws up a smoke-screen between the educator and the public.



*Marriage to her
is no longer
a billowy dream.*

The positive aims of the Family Relationships course were stated thus: Through this study it is hoped

- "That boys and girls in the young adult group (we did not use the misused word *adolescent*) will consider the seriousness of establishing a good home and family.
- "That they will face the opportunity more hopefully, realistically and happily, having had some preparation.

- "That they will be able to contribute positively to their present family situation, using the insights and skills and knowledges they acquire through the course."

The devout hope was expressed that as a result of the Family Relationships course, there would be:

- Fewer divorces
- Fewer broken homes
- Less delinquency
- Less unhappiness among children and parents.

Mutual Support in Home and School

In explaining the goals, it was essential to make clear to the mothers and fathers *and to the students* that the purpose of the course was to *supplement* the foundation laid by the home, not to *supplant* it, which, of course, would be impossible anyhow. We never lost sight of the fact that each boy and each girl enrolled came not from a vacuum but from a home which had its own special culture, philosophy, religion, attitudes, ideals, standards, class pattern, loyalties, etc. We did not *try* to replace, substitute or exchange for these a set of ready-made principles of living and patterns of thinking which we considered to be preferable or superior.



*She likes
her family
better
than ever.*

Nothing could be more damaging to family relationships than to withdraw from the home the support that it badly needed. In as many ways as possible we tried to give continuity to the home's purpose and point of view. Wherever we could, we tried to supplement. Our goal was to send each student back to his family thinking *more* of it, not less . . . *understanding* his family, not condemning it . . . willing to work to help his family, not wishing to wash his hands of it.

We Convert Our Critics

What about the critics? Anticipating difficulties may not always be wise, but we tried to forestall misunderstanding. We invited potential critics into the class and gave them a job to do. Specific questions were turned over to them for discussion. We put them to work with a small group of students.

Intimacy was effective. *We have never failed to convert a critic when he finally and fully' comprehended our goals and our purposes and understood our techniques.* Everybody was in favor of establishing strong, united, moral family life. No one objected to that aim.

We found and won key people. They helped us immeasurably. We got parents in on the homework whenever possible. We helped pupils interpret what they learned to others. We took them into our confidence. We told them *why* adults were likely to be puzzled as to the purpose and merit in any new field of study. We helped them to sell! We checked and double-checked on what was taught and helped the students meet unfair and unjustified attacks when they were made.

The students, after all, are the *only*, the *best* and the *final* line of defense. They can sell or kill the effort. If they find the course helpful and useful, they'll fight to save it, as ours have done upon occasion. In our community, a few times it has been necessary to reinterpret goals and values for the benefit of newcomers who failed to understand our purposes.

"How can we get the study of the family in *our* schools?" is a common question, and a tough one to answer.

To tell other communities exactly how to initiate studies of this type into their schools is impossible, for each school and community has its own peculiar situations and problems. In general, four types of approaches have been tried.

There Are Approaches and Approaches

Type number one is direct, honest, hearty, fearless. It says, "Here's a good idea. Let's try it today, next week or next fall." Then the plunge is made. One is reminded of the dive made by the reckless adolescent who dashes down the springboard, leaps into the air with abandon and—holding his nose tightly for protection—lands with a splash in the pool below. This is a risky approach. No finesse, but often he gets away with it! Often the landing is painful.

Type number two is a timid approach, fearful, hesitant. It says, "We hope you won't mind. We *know* it's dangerous. We'll consider this *awhile* longer." But nothing ever happens. Again we think of another kind of diver who remains indefinitely teetering upon the springboard with arms inscribing graceful arcs but never gathers enough courage

to make the final plunge. Plenty of planning is done, lots of good intentions are formed, but no action results. The course or plan remains in the blueprint stage.

Type number three differs still further. Permission is granted from community and administration, but it is so hampered by fears and restrictions that real confidence is lacking and so real progress is checked. This is the "Yes, my darling daughter, you may hang your clothes on a hickory limb but *don't* go near the water!" approach. "Don't mention sex. Don't mention religion. Don't mention touchy subjects! Don't, don't, don't!"

Finally, there is the reasonably cautious, carefully planned, deliberate approach where confidence is felt because support is present. Here is the diver, mindful of techniques and principles, who leaps with form and grace, without fear and resulting confusion. We tried this one. In our case, it worked.

Increasing Maturity with the Years

So ten years have passed. Certain changes in the type of student body are noticeable. In the first place, the boys and girls come to the course more aware of its purpose than formerly. They are family-conscious, better informed, more "hep." The flood of literature on dating, sex, marriage and child-rearing that has all but swamped the newsstands has had its effect. The students aren't "green" any more. They read articles at home in the apparently innocuous magazines that a wise classroom teacher would be reluctant to handle.



*"How do you know it's love?"—
She isn't interested in
such superficialities.*

Each year the subject matter has to be elevated to a slightly more mature level. The students are displaying great interest in the psychological and sociological aspects of the family. They are, of course, still concerned with their personal problems and family difficulties, but they are rather fed up with shallow debates on the dating, how-do-you-know-it's-love? type of thing.

They are becoming more observant and less willing to believe all they read, an excellent sign.

Interest in babies and young children is more keen than it was when the course first started. Increasingly, the emphasis leans toward the art of getting along with people. The workings of the mind fascinate them. The demand for reading in the field of psychology increases.

They are conscious of the need for more religious emphasis also.

In brief, Family Relationships has come of age. The many graduates who return with their children have only constructive things to say. They talk of "our course," "our room." Said one graduate, mother of two children, "The further away I get from it, the closer it is to me." This leads us to a final question.

There Is No Yardstick for Results

When shall we begin to measure the benefits from such an experience as this course? One year? Two? Ten? Twenty? At what period do human beings seize and act upon a principle, a lesson, an ideal, a technique that was suggested to them in their course? Who knows when the seeds germinate and to what other factors they are related?

No one has given the answers to *those* questions or to *these*:

How many divorces have we prevented or encouraged? We don't know.

How many marriages are happier because of this course? We don't know.

How many premarital pregnancies have we prevented? Encouraged? We don't know.



*She can accept the baby
more easily, love it
more generously.*

How much better off are the young parents and their young children because of our course? We don't know.

How much better off will the next generation of children be whose parents *have had* the parents who took the course? We won't ever know.

How many happier homes do we have? More hopeful husbands and wives? More loving and accepting mothers and fathers? We don't know.

We Are Encouraged to Continue

Where then is the proof of the pudding? There is no proof, but feeble evidence of values received may be found in this kind of thing by one inclined to accept it as valid evidence:

- Parental letters of appreciation and parental recognition of positive changes in children.
- Parental comment (unsolicited).
- Parents voluntarily seek guidance, books, pamphlets.
- Parent study groups on family matters organized through PTA efforts use our course as a spark, using our materials and room.
- Citizen interest expressed in class visits, inquiries and "We wish we had had it."
- Continued heavy enrollment.
- Enrollment runs in families—sisters and brothers of the same family elect to take the course. Those families who are *sold* are *sold*!
- Graduates return to express gratitude and appreciation.
- Nurses find it especially helpful in dealing with patients and patients' families.
- Evaluation from married graduates who return with their babies to renew contacts and to express gratitude (*and* to display their progeny).
- Graduates still keep in touch to offer ideas and suggestions and encouragement. Heavy fan mail.
- Community clergy do more marriage counseling. One states that his is directly as a result of his contact with our classes.

Perhaps in time some valid scientific measuring device will be available for us to use in evaluating results. At present where are there such devices for measuring true "value received" from courses in family relationships, history, civics, health or anything else?

Failure . . . or Success?

For the present we shall lean on rather subjective evaluation. Maybe we shall have to accept the fact that the value, like beauty, is in the eye of the beholder. To the one boy who said sadly, "It didn't do me any good, because I *still* have problems," it appeared to be a failure. To the girl who wrote, "Thank God for Family Relationships. I would sure have been a mess without it!" it was a howling success.



VENEREAL DISEASE NURSING IN HOSPITALS AND CLINICS

Prepared by a committee of the New York Tuberculosis and Health Association's social hygiene division, including Virginia M. Dunbar, R.N., M. Eva Poor, R.N., Frances L. Boyle, R.N., Dorothy McMullen, R.N., Helen Ratushney, R.N., and Carol May Adams, R.N., in collaboration with Drs. Frank C. Combes, Howard Fox, Evan W. Thomas, Bruce Webster and J. A. Goldberg.

Nursing Knowledge and Skill Are Not Enough

One of the principles of the Charter of the United Nations, incorporated in the Constitution of the World Health Organization, reads: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

All nurses must share in the responsibility of achieving the goal of healthy citizenry. In the management of the venereal diseases, much has been written about the public health nurse's role, but little save that which is concerned with technics of treatment has been done to guide the nurse functioning in hospitals and clinics. Many nurses have not been fortunate enough to have studied these problems in their basic education.

In attending patients with any venereal disease or its complications, the nurse must plan her care with an understanding of all its aspects. Technical knowledge and skill are relatively easy to acquire, but the ability to be of help in other areas needs careful preparation. Teaching positive health is a part of nursing care.

In nursing venereal disease patients, it is essential that the nurses, patients and their families learn to view VD as they do other communicable diseases. Attitudes of nurses are fully as important as manual skills and teaching abilities. Because venereal diseases are closely associated with behavior patterns, the nurse must avoid any tendency to censure, condemn or moralize. It is her responsibility to nurse a sick patient, to serve as the liaison between physician and patient, between the patient and his family, and often between hospital and community.

Patients are often extremely sensitive to the attitudes of their medical attendants. The nurse must understand her patients and their immediate needs. In addition, she requires information about their families, personal and financial problems, friends and occupations. With these and other factors in mind, the patients' conduct patterns can be more readily interpreted, and sympathetic and intelligent nursing care provided.

The Venereal Diseases

The advent of sulfonamides, penicillin, chloromycetin, streptomycin and other antibiotics radically changed the treatment of the venereal diseases. Medical measures are now available which practically make it possible to remove them from the realm of major medical, public health and social problems. And yet overenthusiasm, as well as changing national and international situations, may materially alter the chance of early success.

Recent figures on the number of venereal disease cases reported to the U. S. Public Health Service are indicative of the fact that much remains to be done. A total of 545,111 cases was reported in 1950. Many thousands were probably not reported. The distribution of these cases was: syphilis (all stages), 231,567; gonorrhea, 304,066; chancroid, 5,825; granuloma inguinale, 2,017; and lymphogranuloma venereum, 1,636.

Psychogenic Factors

Individualized approach. Psychogenic factors enter largely into the treatment of the patient with a venereal disease. He should be treated as an individual, with special emphasis upon social and economic factors. Various accompanying disturbances present definite problems which can be greatly relieved by the nurse. His possible sense of guilt, inadequacy, lack of group feeling and economic insecurity are entities which must be considered and treated along with the physical effects of the disease.

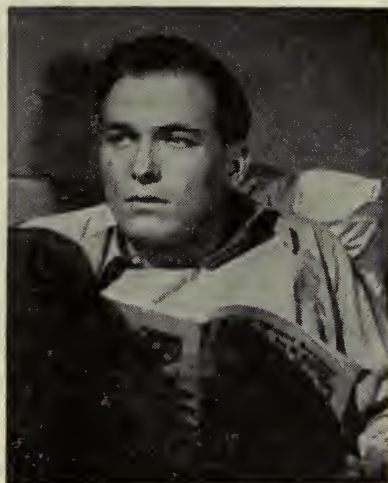
Fears. More often than not, the patient is fearful and resistive to examination and questioning by those who wish to help him. Accompanying these reactions is the element of guilt which he feels over having acquired the disease. He is often considered an outcast by his friends and associates, and no longer has their sympathy and support. He must live through his illness in a constant state of anxiety and worry.

Emphasis should be placed on the patient's illness as a manifestation which requires objective treatment in order to help him get well. Such an attitude on the part of the nurse, which she subconsciously imparts to the patient, can minimize the sense of guilt and change the patient's attitude toward himself and his associates.

Patients' responsibilities. Emphasis must be placed on cooperation between the patient and those caring for him. The need for such coop-



*She doesn't know
whether to love
or to hate
her husband.*



eration requires careful explanation by the nurse and understanding by the patient. His willingness to undertake this responsibility entails the giving of information regarding contacts. He should be made to understand this requirement in terms of the health of others who may have been exposed to infection and possibly need medical treatment.

A sense of responsibility must be developed in regard to his own personal hygiene as it may relate to those who are in contact with or are caring for him. These objectives can be achieved through careful guidance and teaching.

Reaction to diagnosis. Some of the psychological complications are often more distressing than the infection itself, from which the patient may actually suffer little discomfort. For instance, the married man who becomes infected with syphilis presents many serious problems which involve his wife and children. If he is in an infectious stage, he must first of all be convinced of the urgent necessity for him to remain under treatment as directed, and to follow instructions to prevent the possibility of his infection spreading to his wife and children.

Other serious difficulties he faces involve not only the explanation to his wife that he became infected but that it is essential that both she and the children, if any, should report to the clinic for examination.

The sense of guilt on the part of the patient and the almost inevitable recriminations with the probable demand by the wife to know the name of the "other woman" add additional tensions to an already troubled

situation. Then there is the fear that not only may the wife have been infected but the child or children or unborn child may also have become involved.

The wife faces a difficult emotional conflict between an instinctive rejection of her husband because of his unfaithfulness and her possible real love for him. Additional emotional problems relate to the possible expensive treatment, absence from work and loss of wages, fear that the employer may find out and that relatives, friends and neighbors may learn the facts.

Problems similar in nature develop if the man becomes infected with gonorrhea or another venereal disease. He may pass on his gonorrheal infection to his wife and she in turn might not become aware of that fact for a long time, if ever. In such a situation, when a husband has been cured of his infection and continues sexual relations with his wife, he could become reinfected by her. He might then unjustly accuse her of infidelity when she would not know that he had infected her originally.

Whatever the venereal disease and whether the chain of infection started with a husband or wife, similar emotional problems arise. It is essential that the consort of either infected individual should be brought in for examination. The task of explaining the necessity for this step must be carefully carried out before a patient is usually prepared to cooperate with those concerned with his treatment.

When an unmarried man or woman is the hospital or clinic patient, parallel problems creating a sense of guilt, fear, recriminations, etc., also need consideration.

Those treating and caring for venereal disease patients are often called upon for advice and guidance on various matters. A proper understanding of the patient's problems is essential if he is to be assisted in adjusting to the disease and resulting emotional involvements.

Sanitary Code Requirements

Municipal sanitary codes indicate the duties of persons in charge of hospitals, dispensaries and other institutions, and of physicians to report cases of venereal disease. All nurses concerned with the treatment of venereal disease patients should familiarize themselves with these legal requirements intended to promote the public health and to prevent the spread of these communicable diseases. Such regulations as these are of particular import:

- It shall be the duty of the manager, superintendent or person in charge of any correctional institution and of every hospital, dispensary, clinic, asylum or charitable institution promptly to report to the Department of Health the full name, or initials, together with the address, sex,

*State laws
require
laboratory tests.*



age, marital state and occupation of every occupant or inmate thereof or person treated therein, affected with syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale. It shall also be the duty of every physician in the city promptly to make a similar report to the Department of Health relative to any person found by such physician to be affected with syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale.

- All reports made in accordance with the provisions of this section and all records of clinical or laboratory examinations for or indicating the presence of syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale shall be regarded as confidential and shall not be open to inspection by the public or by any person other than the Commissioner of Health, an authorized representative of the Department of Health and such other person as may be authorized by law to inspect such reports or records, and in addition thereto in Health Department clinic cases the Commissioner of Health or his authorized representative may furnish such information as he deems appropriate to a physician or institution giving further treatment or to a midwife or any agency approved by the Commissioner of Health for the purpose of prevention, treatment or social care. The custodian of any such report or record, the said Commissioner or any such other person, institution or agency shall not divulge any part of any such report or record so as to disclose the identity of the person to whom it relates, except as provided by law.

- It shall be the duty of every physician to furnish and deliver to every person found to be affected with syphilis, gonorrhea, chancroid,

VENEREAL DISEASE SUMMARY CHART

	Syphilis	Gonorrhea
CAUSATIVE ORGANISM	<i>Treponema pallidum</i> .	<i>Neisseria gonorrhea</i> (gonococcus).
TRANSMISSION	Sexual intercourse, kissing, pre-natal infection.	Sexual intercourse and ophthalmia infection at birth.
INCUBATION PERIOD	10 to 90 days, average 21 days.	2 to 14 days, usually 3 to 5 days.
CLINICAL SYMPTOMS	<i>Primary</i> —chancre. <i>Secondary</i> —rashes, mucous patches. <i>Early latent</i> —no symptoms or recurrence of infectious lesions after disappearance of secondary lesions. <i>Late (tertiary)</i> . <i>Active manifestations</i> —cardio-vascular, neurosyphilis, gumma, ocular, osseous, visceral, etc.	<i>Male</i> —purulent urethral discharge, burning on urination, pain, inflammation and swelling. <i>Female</i> —possibly no symptoms. Vaginal discharge, pain in abdomen, salpingitis.
DIAGNOSIS	Darkfield examination, serologic tests, case history, clinical signs and symptoms, X-ray, history and physical examination. Spinal fluid examination in latent and late cases.	Smears, cultures, case history and physical examination, clinical signs and symptoms, contact history.
TREATMENT	<i>Early</i> —3 injections of 1,200,000 units of procaine penicillin in oil and aluminum monostearate, injections daily or three times a week. <i>Late or late neurosyphilis</i> —600,000 units daily for 15 days or 1,200,000 units 3 times a week for 8 injections.	One injection of 900,000 units of procaine penicillin in oil and aluminum monostearate. This large dosage intended to treat gonorrhea and also abort syphilis when acquired simultaneously.
CONTACT INVESTIGATION	<i>Primary case</i> —all sexual partners from date of interview back to six weeks before chancre appeared. <i>Spouse</i> —always. <i>Early latent</i> —sexual contacts one year preceding and children. <i>Late latent</i> —spouse and children. <i>Congenital</i> —parents and siblings.	Inquiries for all sexual partners 2 weeks prior to onset of symptoms. For female patients limit inquiries to 3 months prior to clinic visit.

Note: Modifications of the preceding treatment schedules are in use in various hospitals and clinics. Physicians may find it necessary to vary treatment for individual patients.

JUNE, 1951

Chancroid	Granuloma Inguinale	Lymphogranuloma Venereum
Ducrey bacillus.	Donovan bodies.	A specific filterable virus.
Sexual intercourse.	Sexual intercourse.	Sexual intercourse.
2 to 12 days, usually 3 to 5.	Indeterminate; probably 2 to 12 weeks.	5 to 30 days.
Frequent multiple or single, painful, tender, rapidly growing, non-indurated ulceration, ragged edge and dirty gray wet base, swelling in inguinal region, pustule on genitalia and inguinal region.	Beefy, red, granular, shiny, well-defined, granulating ulcer, slowly growing but progressive. Papule on genitalia. Inguinal or perineal ulcers.	Frequently absent. History or presence of a pimple or small ulceration in about $\frac{1}{3}$ of cases; bubos; rectal stricture in late stages. Vesicle on genitalia, fistula with pus, inguinal glands and swelling.
Darkfield examination (to exclude syphilis), skin tests (Ito-Reenstierna), presence of Ducrey bacillus, case history, physical examination, clinical signs and symptoms.	Darkfield (to exclude syphilis), case history, clinical signs and symptoms, history and physical examination. Microscopic examination for Donovan bodies.	Darkfield (to exclude syphilis), case history, clinical signs and symptoms. Frei skin test.
Sulfadiazene, 0.5 gm. every 4 hours for 10 to 14 days. Streptomycin, 1 gm. dissolved in 2 cc. distilled water, injected intramuscularly daily for 3 days. Aureomycin or chloromycetin, one 250 mgm. capsule every 4 hours for 4 doses daily, continued for 5 days.	Streptomycin, 3 gms. by intramuscular injection, daily or every other day for 7 doses. Aureomycin or chloromycetin, two 250 mgm. capsules every 4 hours for 4 doses daily, continued for 10 days.	Aureomycin or chloromycetin, two 250 mgm. capsules every 4 hours for 4 doses daily, continued for 10 to 14 days.
Inquiries for all sexual partners 3 weeks prior to date of onset of symptoms. Limit inquiries to 3 months prior to clinic visit.	Sexual contacts 6 months preceding onset of symptoms.	Sexual contacts 4 to 6 weeks preceding onset of symptoms.

lymphogranuloma venereum or granuloma inguinale a circular of instruction and advice issued or approved by the Department of Health, and to instruct every person found by such physician to be affected with syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale as to the precautions to be taken in order to prevent the communication of the disease to others. No person affected with syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale and no physician treating such a person and no hospital, dispensary, clinic, asylum, charitable or correctional institution where such a person is being treated shall fail to comply with the regulations of the Board of Health or by a negligent act cause, contribute to or promote the spread of such disease.

- Every physician attending pregnant women during gestation shall in the case of every woman so attended take or cause to be taken a sample of blood of such woman at the time of first examination and submit such sample to an approved laboratory for a standard serological test for syphilis. Every other person permitted by law to attend upon pregnant women but not permitted by law to take blood tests shall cause a sample of the blood of a pregnant woman to be taken by a duly licensed physician and submitted to an approved laboratory for a standard serological test for syphilis.

The Interview

It is desirable that the physician responsible for the patient's treatment shall interpret the disease to him; describe the treatment required; explain the importance of furnishing the names and addresses, when possible, of all contacts; and stress the necessity of full cooperation with the physician, the nurse and the social worker.

Where nurses do most of the interviewing and instruction of the patients, the success or failure of an interview will depend not only upon the interviewer's knowledge of the disease but also on her ability to impart this information to the patient in language and terms that he will understand. Often the first contact will set the motivation for the patient's return to the clinic for treatment and follow-up procedures. The clinic organization and the interviewer's attitude toward the patient are important in building up rapport.

The nurse interviewer—if the responsibility devolves upon her—must interpret the disease to the patient; give the name of the disease; advise how it was most likely acquired; explain the causative organism, the difference between the various venereal diseases and why certain procedures will be carried out. It is important to stress necessity for treatment, the amount, type, preparation for treatment on the part of the patient, the need for regularity in clinic attendance, the result the patient may expect from the treatment and the responsibility of the patient not only to himself but to his family, friends and other contacts.

All necessary precautions are to be carefully explained, especially those relating to toilet habits, kissing and sexual relations. The patient should be asked to name his contacts and at the same time be assured that the information will not be divulged. It is important to bring in the contacts for examination and treatment when necessary. If possible, the exact name and address of contacts should be obtained. There may be more than one contact in addition to family and household contacts.

There is also the importance of providing for their treatment as far as time, place, regularity and financial arrangements are concerned. Often a patient will be delinquent because he has to work at the hour that the clinic is held and therefore he should be referred to a private physician or to a clinic which meets his financial and other needs.

The patient gives confidential information about contacts.



At the end of the interview, the *patient* should know:

- The venereal disease he has contracted.
- The treatment needed, where it can be obtained, how much it will cost and clinic hours.
- The importance of regularity in clinic attendance and post-treatment observation.
- The necessary precautions to protect himself and others.
- The importance and desirability of having contacts examined and treated if required.
- The confidential nature of information provided about contacts.
- The interest of the interviewer and other clinic professional staff in helping him achieve an early cure.

At the end of the interview, the *interviewer* should know:

- The patient's address and sufficient identification to trace him in case of delinquency (rent receipt, chauffeur's license, etc.).
- The patient's understanding of his illness and the need for treatment.
- The individual from whom the disease was probably contracted.
- The patient's contacts during the infectious period of the disease and where they can be located.
- The patient's probable cooperation in treatment.
- The patient's need for a follow-up interview.

Contact Investigation

To be successful, contact investigation starts with the infected patient and proceeds cautiously into the home or the community where that person may have acquired the disease and where he may have transmitted it to others. It seeks to discover infection among all intimate contacts. A patient can be expected to withhold information about these contacts because he may be ignorant of the potentialities of the disease.

The nurse should be fully aware of them. It is her obligation to inform the patient of the dangers of the disease to himself and to contacts. Failure to participate in this manner in contact investigation is failure to assume a definite responsibility.

The expression "source of infection" carries an implication of accusation and should be avoided in the approach to both the patient and his contacts. The patient should be asked to identify his sexual contacts, naming the last one first and then all the others he can recall. The variation in the incubation period for each of the venereal diseases may result in inadequate information regarding contacts.

Some nurses may think that contact work is actually completed when this reported "source" is found. Yet every infected person is a potential source of other infections. If further transmission of the disease is to be arrested, information must be sought concerning all sexual contacts over intervals selected to include both the stage of active communicability and the incubation period.

Outpatient Department

Venereal disease clinics. With modern and rapid treatment available for many patients with venereal disease, hospitalization may not be necessary provided well-organized outpatient facilities are available. All patients admitted to a clinic should have a serologic test for syphilis. The venipuncture is frequently made by nurses who, in addition to needing skillful technic, should be able to explain why the test is being done.

*Nurses
frequently make
venipunctures.*



This is a valuable contribution the nurse can make to public health education.

If the test is reported as positive, the patient should be referred to the venereal disease or syphilis clinic. The nurse can play an important role in creating a pleasant, friendly and professional atmosphere. Whenever possible, the physical set-up of the clinic should provide cheerful waiting-rooms as well as treatment and history rooms with privacy for the patients.

It is the responsibility of the nursing staff or others who are assigned to prepare the clinic for the day's activities. During the clinic session the nurse should collect routine specimens, assist the physicians with examinations, chart essential data, complete records for the Department of Health, give intramuscular injections whenever the attending physicians require her to do so, instruct and give guidance to patients and their families.

A patient coming to the clinic for the first time should be met by the nurse who takes the temperature, pulse, respiration, height, weight, urine, and blood for Wassermann or other serologic tests, unless the physicians do the latter. During these activities she has an excellent opportunity to establish good rapport with the patient by a quiet, interested and helpful manner. A real contribution can be made by the clinic nurse in the field of epidemiology if she utilizes these contacts with patients not only to aid in their examination and treatment but also to help discover other cases.

She should assist the patient to understand his illness, its social implications and the necessity for treatment. If the patient is a woman, the nurse should be present when the physician makes his physical examination.

Subsequent clinic visits may require proctoscopy or lumbar puncture. The nurse will make preparations for these procedures, explaining them

to the patient and assisting the physician in the examination. If the treatment includes intramuscular injections, the nurse follows the physician's orders.

At stated intervals she will collect urine specimens or blood.

Before administering a treatment—if that is standard procedure—the nurse should interview the patient to discover any medical problems or symptoms contraindicating such treatment. If she learns of any, the patient should be referred to the physician before treatment is given.

Admission to hospital. Actively infectious patients may be admitted to the hospital—though many hospitals do not admit such patients—and on discharge should continue their treatments in the clinic. A pregnant woman with syphilis may be treated in the clinic until delivery. After discharge from the obstetrical service, whatever subsequent treatment is required by the mother and the baby can be provided in the clinics. Patients with other venereal diseases may be treated in clinics provided home conditions allow proper isolation during the infectious stages and the patients are sufficiently cooperative and intelligent.

Records. It is essential to keep adequate, accurate records on all patients. A treatment sheet on the chart should give a clear picture of treatments, dates, specimens obtained and laboratory reports. This sheet, accurate and complete in every detail, can be used for a quick review of the progress made, and helps in providing necessary material for reports to the Department of Health.

Cooperation and Accuracy Are Essential

VD clinics must work closely with the local public authorities in the interest of public health. In most states syphilis, gonorrhea, chancroid, lymphogranuloma venereum and granuloma inguinale are reportable diseases. To the nurse may be delegated the responsibility of completing the report forms. These provide the Department of Health with valuable information as to diagnosis, infectiousness, treatment given, age and sex groups involved, increases or decreases in numbers and kinds of cases, geographical incidence, adequacy of treatment and areas in need of more intensive health education and treatment facilities. The reports are signed by the physician in charge.

Specimens of blood may be sent to public and other agencies in special containers. Accuracy in this phase of work is another valuable contribution the nurse makes to research programs to better patient care.

Public health nurse. When a clinic is fortunate enough to have a full-time public health nurse, she will carry out part of the program which otherwise devolves upon the clinic nurse and social worker. Her

function may be solely that of teacher and counselor or she may also follow up contacts and see that they are examined and treated if necessary. This latter function requires real skill, for people are usually reluctant to disclose their contacts. A matter-of-fact attitude and freedom from making the patient feel guilty will help her win the patient's confidence. Should patients lapse in treatment, the public health nurse is the logical person to make a home visit to determine the cause and urge resumption of visits to the clinic.

Problems may arise which might best be handled by the social worker or by various agencies in the community. Not only the public health nurse but all nurses need a good working knowledge of the community resources and should use them wisely in the care of their patients.

Other personnel. Clinic nurses require the assistance of an adequate number of clerical workers and attendants or ward maids. The work done by these groups will relieve the nurse of routines which otherwise would make inroads on her time and prevent her from giving as much attention to the patients as she should. To insure a smoothly operating clinic, these nonprofessional workers should be responsible to the nurse.

Inpatient Department

Isolation technic. Patients requiring hospitalization often have not had a period of outpatient treatment. Consequently, all teaching and reassurance must be done by the nurses on the wards. The same skill and attitude apply, regardless of where the patient is treated. One point of difference in the hospital, as compared to the clinic, is the need for stricter isolation technics when infectious lesions are present. The nurse should promptly recognize that all patients must have this procedure explained to them as early as possible, for they readily develop many fears because of it. It tends to intensify their frequent feelings of being outcasts. Such explanation will help to obviate this hazard.

The duration of isolation is determined by regulations of the Department of Health and the rapidity with which treatment renders the patient's disease noncommunicable.

Case assignment. All nursing procedures require careful explanation and individualized care. It is advisable that the case assignment of duties be used, rather than the functional method. Patients benefit greatly by this procedure since they come to know a few nurses well. This is preferable to trying to become accustomed to many nurses in one day. It is apparent that a nurse will know her patient better if she gives all the nursing care.

Health teaching. All clinic and bedside nurses, as well as public health nurses assigned to venereal disease clinics, should share in the education of the patients in ways of effective and healthful living.

Nursing Care of Patients with Neurosyphilis

Safety of patient. Because treatment of all venereal disease is changing rapidly, specific technics have also changed. However, in spite of advances patients with neurosyphilis are still being seen after inadequate therapy in the earlier stages of the disease.

In the hospital, patients with neurosyphilis may be on the medical neurological ward. When the new patient is admitted, his tense and anxious expression immediately indicates that he needs help in adjusting himself to the general hospital atmosphere. The first requirement is for the nurse carefully and tactfully to explain to the patient's family that the diagnosis will not be divulged to the other patients and that the danger of falling—because of his failing vision or staggering gait—will be minimal. Positive efforts—like arranging the furniture conveniently and safely and having the family bring rubber-soled slippers, which will prevent slipping on highly polished floors—are often of more value than mere reassurance.

A venereal disease patient needs protection from an over-solicitous fellow-patient, from a nurse who may disregard him and from fears that beset most individuals afflicted with syphilis. Careful observation of the patient and knowledge of his home environment and relationships to that environment are integral parts of the treatment.

Most difficult is the problem of protecting and caring for patients in the advanced stages of general paresis. This requires skillful psychiatric nursing without support of the psychiatric environment. Difficult problems are presented when such patients, who are subject to fits of excitement, depression, delusions and hallucinations, have to be cared for temporarily or for extended periods in a general hospital.

The nurse's first thought should be for the patient's safety. Windows must be locked (preferably barred), and any equipment that might possibly be dangerous removed from the room without arousing the suspicions of other patients. Occupational therapy, when available, is helpful in diverting the patient and sometimes even in determining the progress or degree of degeneration.

Patients with *tabes dorsalis* and other forms of parenchymatous neurosyphilis should receive the same types of protection. Careful instruction of the entire staff is essential. The moral stigma often associated with these diseases is to be avoided. This can begin in the hospital ward.

Fever therapy. Fever therapy has been used extensively in the past but is rapidly being replaced by antibiotic treatment. However, malarial fever therapy may be ordered. It is usually feared by most patients and requires skillful nursing care. Careful explanations by both the physician and nurse are essential. Ideally, the same nurse should attend the patient throughout the treatment.

Psychiatric problems. When psychiatric problems dominate the picture, hospitalization in an institution for the treatment of mental diseases becomes necessary for the patient's own safety as well as that of his family and the community. While this need will be explained by the physician, it often requires interpretation by the nurse. She must be alert to the fear of such hospitals or even to psychiatric divisions within a general hospital.

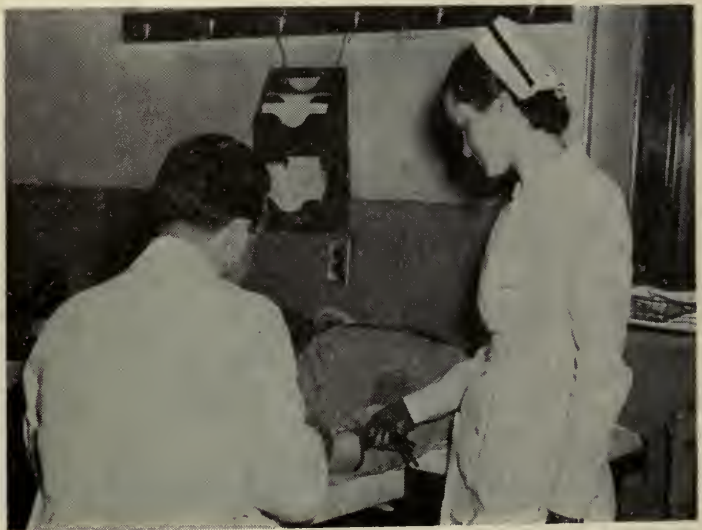
Nursing Care of Patients with Cardiovascular Syphilis

Syphilis is a major cause of heart disease. Nurses may be required to attend many patients with this diagnosis. Skill in caring for individuals with various vascular or cardiovascular diseases is presupposed. In addition, nurses must be prepared to meet the needs created by the fact that syphilis may be the cause. Nursing care is not complete unless the nurse thoroughly understands public health and related aspects of syphilis.

Venereal Disease Nursing in Gynecology

Patients with venereal diseases are also found in those units of the hospital devoted to gynecology. Some patients with a venereal disease, especially gonorrhea, may possibly need radical surgery. Nurses caring for these patients require skill in surgical nursing and a scientific knowledge of venereal diseases, modes of transmission and treatment. Nurses must be prepared to teach the patients in the same understanding and practical manner recommended for those who serve in venereal disease wards and outpatient services.

Sound relationships between physician, nurse and patient will encourage the latter to disclose her source of contact and thus aid in preventing



*Sound
relationships
are
important.*

further spread of the disease. Socio-economic factors which become available in good history-taking may indicate some of the contributory causes of infection. These may be related to low intelligence, lack of emotional satisfaction, frustration and other forms of insecurity.

Venereal Disease Nursing in Obstetrics

Every pregnant woman with a diagnosis of venereal disease may now look forward to giving birth to a healthy infant. In states where serologic tests for syphilis in pregnant women are still not required by law, nurses can help to educate the public to demand that such tests should be made and repeated in six months.

Penicillin therapy for syphilis has almost completely replaced the older methods of treatment. This antibiotic seldom causes severe reactions, is easily administered and may be given successfully over a comparatively short time. All these advantages have lessened the fear of treatment formerly associated with older practices. If treatment is given early in pregnancy and relapse or reinfection follows, the patient may be retreated and still deliver a healthy baby. Treatment late in pregnancy will also cure congenital syphilis in utero. The complete eradication of congenital syphilis is therefore a definite possibility.

Nurses can be of much help in attaining this objective by taking an active part in instructing prospective mothers regarding the absolute necessity for periodic examinations in order that treatment for syphilis, if necessary, and retreatment during pregnancy may be given. The baby born to a syphilitic mother needs examination periodically, even if symptom-free at birth.



*Clinics provide
treatment for
mothers and babies.*

Pregnant women who have been adequately treated for syphilis do not need therapy during subsequent pregnancies. Periodic examinations including serologic tests for syphilis are nevertheless imperative during prenatal care. If these tests are negative, further treatment is not indicated.

Gonorrhea in pregnant women is also successfully treated with penicillin. As a further precaution to prevent ophthalmia neonatorum in the newborn infant, either a 1% solution of silver nitrate or penicillin ointment should be applied to the conjunctivas at birth. Research is still active, and it is anticipated that present forms of therapy may be modified. The important aspect for the nurse is that she should recognize the need for prophylaxis and play an active role in helping to secure it.

*The goal
of the
obstetrical
nurse is
a healthy
baby.*



Chancroid, lymphogranuloma venereum and granuloma inguinale may be safely treated during pregnancy.

Nurses in the maternity field who encounter venereal diseases must be alert to the psychic trauma caused by them. This can be mitigated by helping patients accept the diagnosis as they would that of any other communicable disease. Along with education about the necessary therapy should go reassurance and guidance toward the ultimate goal—giving birth to healthy babies. In addition to participating in therapy, the nurse must also be alert to any underlying social problems. Through education and interpretation of legislative, diagnostic and therapeutic aspects of the venereal diseases, she can make a contribution to their ultimate eradication.

Venereal Disease Nursing in Pediatrics

Premarital and postpartum examinations can help in the elimination of many cases of congenital syphilis. The pregnant woman who has syphilis can give birth to a healthy child if she follows the physician's and nurse's advice and receives adequate treatment. Children born of such mothers should be cared for as normal children. The only difference is the need for close and continued medical supervision and preventive measures, including isolation, as long as may be necessary. Such children, like all others, require adequate love, a good diet, proper housing and hygienic care.

There are many thousands of children in this country who have undiscovered and untreated congenital syphilis. According to the U. S. Public Health Service, 521,581 cases of syphilis were reported in 1943 in the United States and its territories. Of the total, 16,582 (3.2%) were classified as congenital syphilis. By 1950 the total of reported cases had declined to 226,942, of which 15,195 (6.7%) were congenital syphilis cases.

Nurses serving in outpatient departments, on pediatric wards, as school nurses or in the public health field, may come in contact with some of these children. It is therefore important to be aware of the symptoms of the disease and whenever in doubt to refer children with such symptoms to a physician.

Summary

Venereal diseases are a public responsibility requiring close cooperation between the physician, nurse, social worker, technician, patient, his family, friends and the community. In addition to knowledge and skill, a healthy attitude toward the problem is of paramount importance if these diseases are to be successfully prevented and treated.

Bibliography

- Moore, Joseph Earle, *Modern Treatment of Syphilis*. Charles C Thomas, 1941.
- Moore, Joseph Earle, *Penicillin in Syphilis*. Charles C Thomas, 1946.
- Morris, Evangeline Hall, *Public Health Nursing in Syphilis and Gonorrhea*. W. B. Saunders Co., 1948.
- Richardson, Henry B., *Patients Have Families*. The Commonwealth Fund, 1945.
- Stokes, John H., *Dermatology and Syphilology for Nurses*. W. B. Saunders Co., 1940.
- Thomas, Evan W., *Syphilis—It's Control and Management*. Macmillan, 1949.
- Social Hygiene Committee, New York Tuberculosis and Health Association*. All pamphlets in the series prepared under the auspices of the Association of Syphilis Clinics.
- Social Hygiene Committee, New York Tuberculosis and Health Association*. "Social Hygiene." A monthly bulletin.



NEW LIGHT ON THE SEX OFFENDER

Since 1949 when Michigan's Governor G. Mennen Williams asked them to form a study committee on the deviated criminal sex offender, 23 Michiganders have:

- Corresponded with or interviewed 900 persons competent to comment on the sex offender.
- Studied the laws of other states pertaining to the sex offender.
- Studied the case histories of 220 criminal psychopaths, 65 sex offenders on prison parole, and 348 juvenile sex offenders.
- Tested the attitudes toward sex offenders of a random sample of 100 individuals in the general public.
- Recommended new legislation, administrative reforms and activities by voluntary groups.

The Commission's findings formed the basis of a report (published recently in a limited edition) and of a panel discussion during the Michigan Welfare Conference last fall. Sanely presented, simply stated, the findings form a guide for citizen action and agency policies to alleviate the social problems presented by the sex deviate and sex offender.

In the knowledge that human resources are America's top priority, the Michigan laymen and professional workers on the Commission outlined to the Welfare Conference the factors that are vital in any consideration of the sex offender: the emotional prejudice of sexuality, the characteristics of the sex offender, present methods of treatment, the benefits of wise legislation, and the individual's responsibility for the moral and ethical level of our society. Some of their observations follow.

The Emotional Prejudice of Sexuality

by Raymond W. Waggoner, M.D.

It is difficult to change fixed attitudes and ideas about sex. Theories sometimes coincide but more frequently they are contradictory. The Kinsey Report made no mention of psychological aspects. The sex criminal is not the major problem news items would have us believe.

To identify the statutory sex crime with degeneration is inaccurate. (Nearly as many women are killed by their husbands as by sex "fiends.") In actuality, nearly everybody has broken some statute on sex crime at one time or another in his life.

The dynamic approach to sexuality began in the field described as psychoanalysis. There are two basic drives:

- The drive to procreation.
- The drive towards self-preservation.

All drives are theoretically based on pleasure, but in sex pathology the common denominator is the kind of stimulation which occurs. For example, physical punishment of a child by a parent may be the stimulus which leads to masochism or sadism.

Sex deviation is exceedingly common, for any sexual activity can be called abnormal which does not lead to bisexual activity. Furthermore, the designation "abnormal" depends on what the group in which a person finds himself considers abnormal. As an example, extramarital relations are accepted by southern Europeans but are not in many other cultures.

The sexual psychopath is something different. He has little or no conscience, an inability to relate to others and a greater than average degree of aggressive sex drive. He can commit an antisocial sex act and have no feeling of guilt afterwards. He is dangerous because he appears on the surface to be able to relate to other people. He shows an exaggeration of the normal drive which exists in everybody, but without consideration for anybody but himself.

Sexual deviation as we are concerned about it is not an inherited trait. It results from a residual disturbance of the psychosexual development in childhood. In each of the three psychosexual phases of narcissism, homosexuality and heterosexuality there is a residual, and some individuals have more residual than normal.

There are two kinds of sexual abnormality. In the individual it shows itself in too much sex drive or too little sex drive. I consider the latter the more important. More crimes are committed by the second group than by the first. The crimes of group two are committed in an attempt to prove the members of it have a strong sex drive, to prove they are "average." The important consideration is the individual toward whom they have this drive.



This father is showing his son the right direction.

Their methods are variable. Exhibitionism is common, so common that I'm not sure it is a deviation. There are voyeurism, sadism and masochism. Some deviations are not dangerous to society and some are.

To boil it down, a sex offender is one who manifests antisocial behavior and gets caught. Often the victim is not a true offender but is made so by the hysteria of those around him.

Security in childhood is the best protection in adulthood against sexual deviation. Sex instruction should be given a child over a long period of time and not in one package. A child gains security when he can approach a parent and obtain healthy sex information. If information is healthily given, a child must eventually think of sex as natural, and a beautiful thing. He should see it in terms of good relationships between and with his parents and then by his own experience.

What the Commission Learned

by Donald M. D. Thurber

In 1948 there were 5,000 complaints of sex crimes in Michigan. A great many sex crimes were not reported. Of those reported, 60% were of the more serious type classified as felonies, while 40% were listed as misdemeanors. Urban areas had above the average of reported sex crimes, but some rural areas were also above the average, including Osceola, Clare, Newaygo, Midland, Isabella and Mecosta counties in Michigan. There was no sharp line of demarcation between urban and rural settings in the seriousness of offenses.

Only 3% of all crimes reported fall in the classification of sex crimes. At the prison level this per cent rises, so that in the Michigan prison population 15½% of the inmates are convicted sex offenders. Taxpayers should be concerned.

In the juvenile population 7% of the boy delinquents appear before the courts on sex charges. It is known that in Wayne County one in six will be back as an adult sex offender. The error is that we fail to intercept what causes later trouble. Investigation has revealed that juvenile sex offenders return before the court twice as frequently in adulthood as other juvenile offenders.

In Detroit three-fourths of those who committed sex crimes against children in a recent year knew the child victim. This gives the lie to the notion of "fiends" jumping upon unsuspecting children.

A fallacy we all share is that sex offenders do poorly on release, for in actuality their record on parole is better than non-sex offenders. Perhaps some of this is due to greater care being given to the selection of sex offenders for release. They are more apt to be required to serve their full sentence than are non-sex offenders. Nevertheless, the fact remains that there are less than half the parole violations by sex parolees than by non-sex parolees. A tenseness develops in the paroled sex offender and a desperate attempt to control his sex drives lest he be returned to prison, but there has been no help for his basic difficulties.

The penalties for sex crimes written in the law were studied and found to have slight deterring power. The conclusion is that a penalty does not deter a crime the cause of which is imbedded in the personality. Therefore, our Commission has decided that we must look to what is happening to children in the molding of personality to see whether the problem under discussion will become worse or better. Estimates are that 3% of our present school children have emotional difficulties, and some researchers have put the number as high as 10%. We must be aware that raw material is building up and sex offenses are sure of continuing.

Another fallacy in public thinking has been the belief that more serious crimes are worked up to by sex offenders who start with lesser sex crimes. "Nip the lesser crimes in the bud before they become more serious" has been the common belief. This is erroneous thinking. Experience has proved there is little likelihood that a sex offender will abandon one form of sex behavior for another.

*VD — a penalty
the sex offender
more frequently
has to pay.*



These are some of the characteristics of the sex offender, as revealed by the Commission's study:

- He tends to get into more trouble than the non-sex offender.
- He has more difficulty in making a sexual adjustment in and out of marriage.
- He exhibits greater emotional disturbance.
- He has a higher rate of venereal infection.
- He has 20% lower intelligence than does the general population.
- He is twice as likely to be wifeless as are men in the general population.

There is a common thread linking all legal sex offenders and this is the presence of disturbed relationships in infancy and childhood. Fifty per cent come from broken homes, as compared to 20% in the general population. Many offenders were found to have been exposed to cultures at sharp variance with the dominant culture in the area in which they resided as children or adults.

The amount spent on research on this subject has been infinitesimally small. The Commission's general plan calls for the spending of \$50,000 of state money in research over a period of five years and in developing clinical treatment and parental and mental hygiene education in child-rearing.

How Michigan Handles the Sex Deviate and the Sex Offender

by Eleonore L. Hutzell

The Commission sent informational questionnaires on resources and practices both to agencies in the private social work field and to those in the official group. The officials answered the questionnaires better. Those in the private field offered enlightening interviews and discussions.

Their Conclusions

Their conclusions were:

- Sex offenses are not a specific isolated problem. They are part of a general disturbance. In many cases, the agency does not have sufficient evidence on which to base a diagnosis of sexual disorder.
- Resources and present treatment practices vary sharply among the agencies.
- Professionally trained social workers and agencies employing them can most effectively identify sex deviates and prevent sex offenses.
- Resources should be:
 - Mental health clinics, inpatient and outpatient.
 - Children's guidance centers.
 - Private psychiatrists.
 - Facilities for the minor personality maladjustments and agencies with specially skilled workers for help with deeper problems.

And Their Recommendations

Their recommendations were:

- That there should be an extension of community mental hygiene facilities (clinics).
- That inpatient services for very disturbed children be increased.
- That outpatient psychiatric services for adults be extended.
- That the programs of adult and children's clinics be evaluated at regular intervals. If they are not giving service to sexually disturbed persons, a special clinic for such should be established.
- That sex deviates be evaluated experimentally to detect elements of treatability.
- That the leisure-time needs of the returned offender be studied and that the recreation activities in the community be reviewed to see if they can meet the needs of those with a potential for negative behavior.

*Won't a
courtroom
ordeal
deepen
my child's
injury?*



We know a court trial is a bad experience for a child victim, but it is hoped the procedure can be better handled. In the past parents and social workers have often waived legal action because of the trauma to the victim. Trained people are needed in each police department to help children in these experiences. There is need also for the law to speed up cases and not allow them to drag on. The child and the community would both be better served.

What Legislation Has to Offer

by Hon. James E. O'Neill

The Commission has recommended change in the probate statutes so that selected sex deviates can be committed through the Probate Courts with a view to treating their emotional disturbance, that is, those not to be charged with a violation of the law.

A psychiatric division in the State Department of Correction will offer much if combined with a one-day-to-life sentence. This plan allows treatment if it will do any good. The offenders are detained for sufficient periods so that more can be learned of the characteristics of these individuals. Part of the purpose of the indeterminate sentence is to detect the dangerous potentials, so that they need never be released if they show no improvement.

A great part of the Commission's work pertained to new degrees, definitions and distinctions in sex laws.



*The problem
of the
sex offender
is everybody's
concern.*

The Problem Belongs to All of Us

by Reverend William B. Sperry

The problem of sex offenders belongs to everybody. We are all responsible for the moral and ethical climate in which children grow up. The subject of the discussion is not only the narrow problem of sexual deviation. Happy, well-adjusted persons are not deviated. Anything that we can do to apply mental hygiene principles is our goal.

The Commission advocated:

- Premarital clinics for parents.
- Counselors on family problems within trade unions, businesses, churches, PTA's, etc.
- Resources for the promotion of better mental health. If need be, the development of more resources.
- In-service training in basic mental hygiene for court officers, teachers, policewomen and all other agencies dealing with children.

The chance that the sex offender will repeat is greater if he is not welcomed back into society. Character needs reinforcement so that it becomes easy for both the growing and the mature to say "yes" to what is right and "no" to what is wrong.

BOOK NOTES

Paul Ehrlich, by Martha Marquardt. New York, Henry Schuman, 1951. 255p. \$3.50.

In spite of its uncritical approach, this highly personalized biography, full of anecdotes regarding Paul Ehrlich, is stimulating, amusing reading. The author was Ehrlich's personal secretary from 1902 until his death in August, 1915—the period of his greatest accomplishment and of world-wide recognition.

Miss Marquardt manages to convey a remarkably complete picture of Ehrlich's personality, his daily routine in his laboratory and at home, his absent-mindedness, his geniality, his intense devotion to scientific research to the exclusion of virtually every other interest except his immediate family.

One sees the small, slight figure of Ehrlich, cigar box under his left arm, hurrying about the Frankfurt Serum-Institute and the Georg Speyer-Haus, arguing, encouraging, personally directing every step of numerous research projects, incessantly smoking, writing formulas on his stiffly starched cuffs and shirt front, on doors, walls, tables, shouting to his servant, singing off-tune one single song throughout his whole life, cheating himself at solitaire, enthusing over the discoveries and victories of others.

From the beginning of his medical education until his death, Ehrlich concentrated on a specific problem, the investigation of "the idea of a chemical binding of heterogeneous substances to the protoplasm," a field of inquiry which he first defined in his doctor's dissertation.

All that Ehrlich accomplished in immunology and chemotherapy grew out of his study of this limited field. He was accustomed to remark to the numerous young men who worked with him that the human mind is of very limited capacity and one should not fill it up with too great a diversity of materials. This is what he meant by saying he was a "monoman," a one-idea man.

Overlooking the uncritical—not to say adoring—attitude of the author, one could wish that she had dealt a little more fully with Hedwig Pinkus Ehrlich. Those of us who knew Frau Ehrlich feel sure that a person of such unusual charm and warmth must have exerted a great influence over the genius whose discovery of salvarsan was only one, and perhaps not the greatest, of his contributions to human welfare.

CHARLES WALTER CLARKE, M.D.

• • •

How to Be Happy Though Young, by George Lawton. New York, Vanguard Press, 1949. Reprinted from *Senior Scholastic*. 300p. \$3.00.

Actual letters written by young people, each voicing a particular

problem, are answered by Dr. Lawton in letters expressing his opinions as modified by the ideas of groups of young people with whom he has worked. These pieces were previously published in *Scholastic*.

The letters, some of which involve *Getting Along with Your Family* and *Getting Along with the Opposite Sex*, are poignant in their sincerity and are answered realistically by the author out of his understanding and psychological insight. Never does he patronize, always he gives kind, wise, reassuring advice to his questioners.

The book should help bewildered young people, parents and teachers.

• • •

Administrative Medicine, edited by Haven Emerson, M.D. New York, Thomas Nelson and Sons, 1941, 1951. 1007p. \$10.00.

Reprinted from the *Nelson Loose Leaf Medicine Series*, 1928, this collection of pieces by 57 experts and specialists is more accessible in form than was previously the case.

Individual contributions are grouped under four general categories: development of organized care of the sick in chronologic sequence from its original function of general hospital care of bed patients; services for the sick by institutions of higher education and by the federal government, both civilian and military; structure of public health services from

the local unit to the World Health Organization; and a description of special contemporary public health functions in the United States. Chapters have been revised and rewritten and new ones added.

The excellent and authoritative chapter on *Control of the Venereal Diseases* was written by Dr. Charles Walter Clarke, and other chapters refer briefly to this subject.

Since the date for the compilation of VD data is 1947 or 1948, newer developments in this field are missing, such as authoritative discussion of penicillin prophylaxis or immediate treatment of those exposed to VD, of antibiotics in the prevention of ophthalmia neonatorum, of newer evaluation studies in case-finding techniques and of decreased federal allocations. None of these newer developments negate the basic soundness of administrative procedures.

As an authoritative reference, this volume will appeal to a wide audience—physician, board member, philanthropist, government officer and health worker in general or specialized fields.

NORMAN R. INGRAHAM, JR., M.D.

• • •

Problems of Social Policy, by Richard M. Titmuss. London, H. M. Stationery Office and Longmans, Green and Company, 1950. 596p. 25s (\$3.50).

As part of the social history of World War II, this study of the evacuation of mothers and children from the cities of England

reveals the changes wrought in the family by the war.

The destruction of homes and crowded housing, working mothers, fathers in service, disorganized school systems, evacuated or working children, a shifting, restless population—all these conditions explain why the formative influence of the home on children's character and moral development was weakening.

• • •

Elmtown's Youth, by August B. Hollingshead. New York, John Wiley and Sons, 1949. 480p. \$5.00.

Data on the behavior of adolescents in a typical midwestern town, of rigid social stratification, were collected by the author and his wife from personal, documentary and observational sources.

After a study of the young people and their friends, their conversations and their community activities, the authors concluded that the social behavior of these adolescents was related fundamentally to the social positions of their families. The physical and psychological phenomena of their stage of development were of less significance. Cliques, dating patterns, leisure-time activities, amount of education—all seemed to lead back to family social position.

The poor boy must use his spare time earning money to help support his family, not to date girls, and certainly not upper-class girls. The same is not necessarily true

of the lower-class girl. The upper classes are preponderantly represented in extra-curricular activities and high school class offices, but not in the police courts where family position once more wields a powerful influence.

What emerges is a cruel, undemocratic system of class ramification, enveloping every community institution, the school and youth itself, determining youthful social behavior, unyielding because of its hereditary nature.

• • •

Marriage Analysis; Foundations for Successful Family Life, by Harold T. Christensen. New York, Ronald Press, 1950. 510p. \$4.50.

Of interest to students and teachers, this book analyzes the problems of marriage, emphasizes the personal relationships of men and women during courtship and marriage.

Once the causes of marital breakdowns are discovered, an effort can be made to adjust individuals and environmental factors. Personal inadequacy and certain elements in modern culture militate against successful marriage.

Divided into four parts, the book covers such material as the similarities and differences of men and women, personality backgrounds, choosing a mate, parent-hood and living without a mate.

Each chapter closes with a list of problems and projects to stimulate discussion, and a short bibliography.

The Facts of Life from Birth to Death, by Louis I. Dublin. New York, Macmillan Company, 1951. 461p. \$4.95.

This compilation of health facts should prove valuable to biology students, teachers, physicians and social workers, interested as they are in data about population, birth, marriage, health and longevity.

This book is the result of years of research by the statistical staff of the Metropolitan Life Insurance Company.

Chapters on the pattern of marriage, the average American family and marital dissolution are loaded with information in concise form. Answers to questions about VD reveal that mortality from syphilis is four times as high for divorced men as for married men, that there are estimated to be more than 2,000,000 deaths from syphilis in the world annually.

A question - and - answer approach, covering a broad area, ample references according to subject and a detailed index make it easy for the reader to find the answer he wants.

• • •

The Practice of Marriage Counseling, by Emily Hartshorne Mudd. New York, Association Press, 1951. 336p. \$4.50.

When someone in a field of service records the results of years of successful experience for the benefit of others, as Dr. Mudd has done

in this book, it is always a real contribution. Actual case histories of clients of the Philadelphia Marriage Council and material on the process of counseling are outstanding features of this study.

Here we do not find high-flown theories; we find facts, practical and successful ways to do marriage counseling.

Her analysis of the characteristics of the clients of the Philadelphia Marriage Council is also challenging reading . . . statistics come to life and have real meaning. Dr. Mudd carefully gives the limitations of her findings, the kind of sample which it represents in comparison to the population of the United States as a whole; she in no way over- or under-rates its value.

The early chapters are devoted to the history of marriage counseling and a survey of functioning marriage counseling services in the United States. The bibliography is one of the best that can be found on the subject, amazingly complete and 19 pages long.

Appendix A lists names and addresses of national and local organizations offering marriage counseling. Appendix B, reporting services dated from October, 1950, to April, 1951, covers their history, staff, clients, methods and philosophy, fee, educational, research and in-service training programs. There are name and subject indices.

The book contains material suitable for college classrooms concerned with training high school

counselors as well as marriage counselors. It has value for the beginning counselor who, although school-trained, lacks experience and confidence. It is a good book for the person who needs marriage counseling either in preparation for marriage or to save a marriage. It is excellent for the civic leader as inspirational reading that might lead to the formation of a marriage counseling center in his community. It has a special appeal for the person who loves to interpret statistics. It is good mental hygiene for anyone who reads it.

The Practice of Marriage Counseling certainly deserves to be in public libraries. It should be classified under "education" for the teachers' section as well as under "marriage," "counseling" and "sex." Its readability, brevity and comprehensiveness should make it a rather popular circulating book.

PAYTON KENNEDY

• • •

Sex Offenses, by Manfred S. Guttmacher, M.D. New York, W. W. Norton and Company, Inc., 1951. 153p. \$2.50.

Actually the fourth of a series of the "Jacob Gimbel Lectureship on Sex Psychology," this book is divided into three chapters: *The Problem and Its Causes*, *Clinical Aspects* and *Treatment and Prevention*. There is an adequate index.

Dr. Guttmacher has accomplished extremely well his announced purpose: "To present this complex and controversial subject from the point of view of the clinician . . . (in) . . . terms that are intelligible to laymen, without being over-simplified." Writing with ease and lucidity, he treats soberly of a topic which only too readily lends itself to sensationalism or conjecture. Certain points are illustrated by well-chosen clinical excerpts and vignettes from his rich experience.

The few faults I found with the book were irrelevant to the purpose for which it is intended.

The insufficiently footnoted bibliographic references impair its usefulness as a reference work. Dr. Guttmacher's 20 years of experience as psychiatric consultant to the Supreme Bench of Baltimore provide a wealth of clinical material, but offer insufficiently detailed study of individual cases to permit adding to our understanding of the psychodynamics of sexual deviation. It would be unfair to consider this as a criticism since Dr. Guttmacher concedes this point and does not take scientific license in "theorizing" loosely beyond the limits of his clinical observations.

In view of the current public hysteria about this topic and the irrational behavior this problem sometimes seems to produce in otherwise objective people, this book is a must for public libraries and for the personal libraries of readers of the *Journal of Social Hygiene*.

BERNARD A. CRUVANT, M.D.

Your Best Friends Are Your Children, by Agnes E. Benedict and Adele Franklin. New York, Appleton-Century-Crofts, 1951. 310p. \$3.00.

A pleasant successor to *The Happy Home: a Guide to Family Living*, this volume does not divorce the child from his family relationships nor set him up as a psychological phenomenon, as do many child-study books. Instead, it sees him as a human being and interprets him to his parents in reassuring, easy-to-understand terms that nevertheless are acceptable to modern psychological insights.

The authors ask parents to see their children as potential friends. To do this, parents must first realize that they, too, are capable of growth and change, and that their adult world is one which their children enjoy sharing.

By concerted action, both parents can accomplish far more than the individual parent to insure wholesome recreation for teenagers. "Boys and girls who have a good relationship with their parents, and whose sexual education has been natural and wholesome, can generally be depended upon to take care of themselves."

The normal parent without serious emotional difficulties will find help and reassurance in the common-sense advice of this book,

clarified by means of every-day situations in the average American home.

• • •

Psychological Dynamics of Health Education. Proceedings of the Eastern States Health Education Conference, 1950. New York, Columbia University Press, 1951. 134p. \$2.50.

For doctors, nurses, health educators and interested laymen, this book concerns individual motivations that influence the effectiveness of health education.

In his chapter, *Problems of Motivation in Venereal Disease Education*, John A. Morsell recognizes that social hygiene concerns the whole personality, and its accomplishment requires the efforts of the VD educator, whose most difficult problem is getting people to seek voluntarily professional attention for suspected VD. In the interests of economy and efficiency, it is important to keep at a minimum two groups: those who think they are infected when they are not and who must be tested if they request it; and those who are infected but do nothing, whether they suspect the infection or not.

Among other chapters of social hygiene significance are *Adolescence*, by Phyllis Greenacre, M.D., and *The Parent Group*, by Thomas A. C. Rennie, M.D.

HAVE YOU . . .

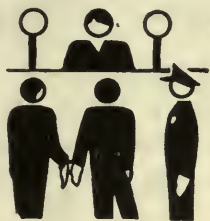
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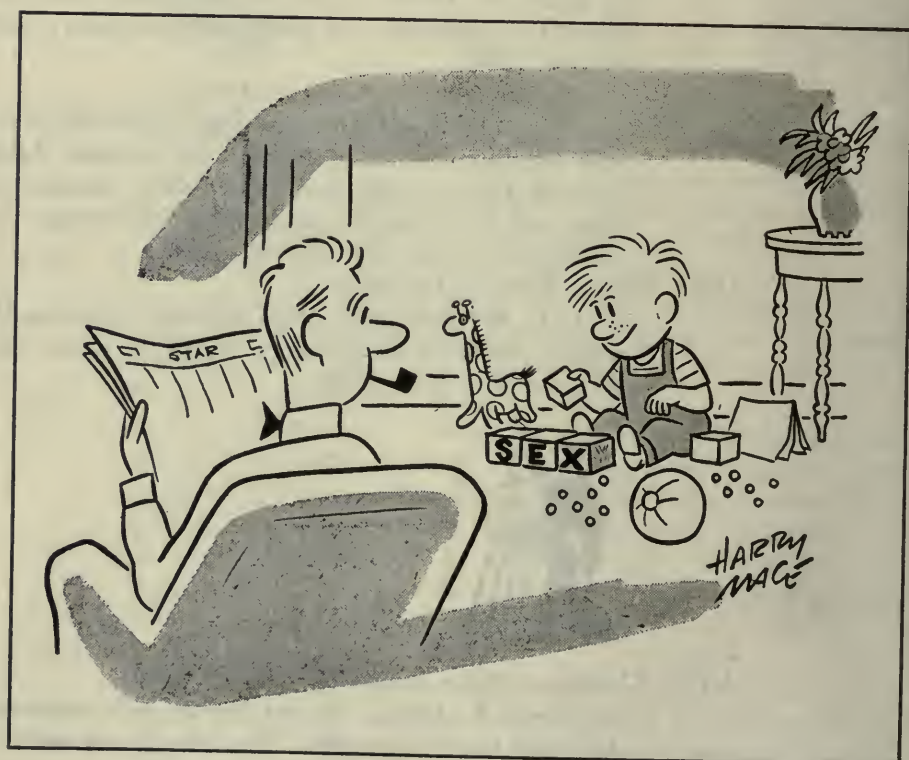
A-771 The Role of the American Social Hygiene Association
These Tools Are Yours.

A-428 Social Hygiene Films from the American Social Hygiene Association.

A-444 Social Hygiene Pamphlets; A Classified List.

A-453 Social Hygiene Bookshelf (an annotated list revised October, 1951).

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BEHIND THE BY-LINES



Elizabeth S. Force

Lecturer, writer and a pioneer in the teaching of family relationships in Toms River High School, Mrs. Force did graduate work at New York University and studied under a scholarship with Dr. Popenoe and Mrs. Strain at Mills College. She has taught at the New Jersey College for Women and was course discussion leader at the University of Pennsylvania. Editor and contributor to professional journals, she likes books, music and western ranch life.



Jacob A. Goldberg

Originator of National Social Hygiene Day and director of the New York Tuberculosis and Health Association's social hygiene division, Dr. Goldberg is a New Yorker by birth and education. He received his M.A. and Ph.D. degrees from Columbia University. Secretary-treasurer of the Association of Social Hygiene Secretaries and lecturer at New York University College of Medicine, he is a well-known author, "The Camp Counselor" being his latest book. He and his wife, Dr. Rosamond J. Webster, have two children, Helen and Arthur.



Donald M. D. Thurber

Mr. Thurber is executive director of the Governor's Study Commission on the Deviated Criminal Sex Offender, Michigan, and executive secretary of the Mayor's Committee on the Rehabilitation of Narcotic Addicts, Detroit.

Dr. Waggoner is director of the Neuropsychiatric Institute at Ann Arbor, Mich.

Miss Hutzel was formerly deputy commissioner of the Detroit Police Department.

Judge O'Neill is judge of the Tenth Judicial Circuit Court at Saginaw, Mich.

Rev. Mr. Sperry is rector of Christ Church, Detroit.

The Last Word

The American Social Hygiene Association will hold its annual business meeting in New York City, February 6, 1952, in the Skytop Room on the 18th floor of the Hotel Statler, 7th Avenue and 33rd Street. There will be two sessions:

3:30 p.m. Annual business meeting of members, with reports of committees, election of officers and presentation of the executive director's annual report.

A short program will emphasize the need of preinduction training for members of the Armed Forces and will include a movie, followed by tea.

5:00 p.m. First meeting of the members of the 1952 Board of Directors.

Members may submit suggestions and proposals regarding program, selection of officers and administration of the Association's affairs for referral to the appropriate standing committees and the Board of Directors for study and action.

WINIFRED N. PRINCE, *Secretary*
American Social Hygiene Association

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journal of SOCIAL HYGIENE

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About our cover . . .

Lincoln and his family after the death of Tad. An engraving by William Sartain from a painting by S. B. Waugh. Eleventh of a series of Journal covers on family life . . . Photograph courtesy of Library of Congress, copyright, 1866.

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THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association. Subscription price: \$3.00 per year. Single copy: 35¢.



*Sex is not a secret
when they learn
the truth about it.*

PARTNERS IN SEX EDUCATION

by Esther Emerson Sweeney
Director of Community Service
American Social Hygiene Association

The use of the words *sex* and *education*, without benefit of conjunction, has given rise to vast misunderstandings and innumerable, still inconclusive debates.

Yet for many years the nation's most high-minded and serious educators have written and talked about sex education in unmistakably clear language. By their definition, sex education includes a minimum of sex facts and a maximum of attitude-development concepts. These concepts deal with the family as the basic unit of society; with the personal responsibility of each human being for behavior; with the ethical aspects of dating, courtship and marriage; and with the whole range of social, psychological, economic, moral and spiritual factors that govern in all society the relations between the sexes.

None of these educators—Dr. William Freeman Snow, Dr. Thomas Galloway, Dr. Mabel Grier Lesher, to name but a few—have viewed sex education as other than a primary and continuing parental responsibility. They have seen clearly, though, that the church, the school and many community agencies might (indeed, under appropriate circumstances, *should*) supplement and complement the parental task.

A Definition of Terms

Later proponents and opponents of sex education have frequently failed, however, to define terms when discussing the subject. Since both tended

to limit their concepts of what "the other side" was talking about and often failed to revert to what serious educators had included in their statements on sex education, other terms that seemed more descriptive came into use: *education for health and human relations, family life education, education for responsible parenthood, etc.*

To some extent this reduced the temperature of discussions, but it did not actually clear the air. With the exception of professional leaders in the field of family life education (or sex education, if you will), there are still too many over-zealous proponents who fail to define terms, while equally zealous opponents often think that "family life education" is merely a way of masking proposals to "teach sex" in the classroom and still fail to demand a definition of terms.

The Supplementary Role of the School

We continue to have a grave responsibility towards children and young people that must be wisely, carefully pursued. It is a responsibility that must not be shirked and yet can never be permitted to take on the character of usurpation of parental right and duty. Whether we use the words *sex education* or *family life education*, the school has a role to play. It is the responsibility of all of us to insure that the job be done soundly and within the broadest framework of genuine preparation of young people for their contributions to society as men and women, husbands and wives, fathers and mothers in the future.

No one can deny that parents are the child's first and continuing teachers in all that has to do with the relations between the sexes and with development in every child of a sound conscience in regard to the whole moral



*Children reflect
their mother's
love.*

code. Formally and informally, by word, example and attitudes, by what parents say or fail to say, they function as educators in family life—good, poor or indifferent.

The case for sex education in the schools cannot rest on the fact that some parents are poorly equipped for their job. That situation can and must be remedied by adult education. For even if every parent in the United States *wanted* his child's sex education to become the total responsibility of the school, educators would be the last people to accept this as a workable plan. They realize too well that parents would still be unconsciously educating in the home by the very way they behave towards each other, by their casual discussions of a neighbor's divorce, by a thousand and one manifestations of their own attitudes towards marriage and parenthood, towards morality and individual rights and duties.

School Experiences Cannot Be Isolated

No, the case for family life education in the schools rests on altogether different grounds. It is founded upon the fact that any effort to separate the child's school experiences from family life considerations is completely artificial. Such artificiality would not only spell failure by the school to complement the work of parents but would, in fact, undermine the work of parents and the influence of the home. The child cannot live a compartmentalized life, divided neatly between home and school. To attempt such compartmentalization is to destroy the best efforts of both parents and teachers.

Let us take a brief glance at the child's own experience in the classroom. Should it be, *can* it be limited to learning only those things which the parent, for want of specialized preparation, cannot teach? Parents readily agree that the school should teach arithmetic. But can the child learn arithmetic without some reference to reality? What could be more real than problems of budgeting, and do these problems not instantly summon



*Facts plus
attitudes.*

up families, family responsibilities, interrelationships between all members of the family?

Parents agree that the child can learn to read better in the school than he can, generally speaking, at home. But what shall he read? If he reads about families, about parents and their children, is he to be limited to discussion of episodes or style?

Even in fields in which many parents possess far more skill and adequacy than do many teachers—nutrition, homemaking, interior decoration—few parents would think of demanding that teachers quit usurping parental roles as educators.

One could continue indefinitely to list the classroom situations that are part and parcel of family life education, situations that would be sterile and meaningless without teacher orientation to family life education concepts. But lest it be thought that the question of sex information, as such, is being evaded here, let us look quite honestly at that particular, though limited, aspect of family life education.

Sex Cannot Be Ignored in the Classroom

Classroom situations arise constantly, naturally and simply that give rise to questions that cannot be ignored: the school cat has kittens, a teacher returns from leave after having a baby, plant and animal reproduction are the substance of science classes. If we evade questions, we are still providing a form of sex education—education in how “evil” sex is, education in how *not* to ask adults, possibly education in how adventurous it is to get together with one’s pals for a taste of the forbidden answers.

This does not mean, of course, that every possible opportunity to answer questions relating to reproduction is to be pounced upon as an opportunity for an extended diatribe on the subject nor would any but a neurotically warped teacher think it does. On the other hand, a calm, dispassionate answer to a question—leading always from facts to attitudes—is essential unless by evasion we are prepared to have children seek their answers in prurient and often indecent ways. We cannot deceive ourselves into thinking that a teacher’s embarrassed silence will simply send the child home to Mother and Daddy for his answers.

The subject matter in the classroom—nature study, biology, botany, etc.—provides the obvious springboard for most discussion of reproduction. In the hands of a properly trained teacher such subjects provide especially fine opportunities to point up the wondrousness of creation, the tremendous difference between plant and animal reproduction and the reproduction by which a unique, responsible, moral and social being—a *human* being—is born.

Clearly the school must meet, one way or another, the whole question of family life education as a limited but genuine responsibility. The

issue is *how* this can be done so that the child may be adequately protected from intense exposure to factual information, so that there may be no separation of information from attitude development, so that decent moral values are inculcated.

Integration from the First Grade

There are no short cuts. In order to escape the hazards and limitations of being merely sex fact instruction, family life education must begin in the very first school years. It must be integrated into all possible subject matter in the curriculum. It must be carried out by teachers who are properly trained. It must be adequately supervised.



*Family life
education
reaches down
to the first
grade.*

Training in family life education is still being provided on a pre-service basis by far too few colleges and teacher-training institutions. One can only wonder how realistically the average teacher is being prepared to supplement and complement the home—surely a basic task of all education. Such training cannot continue to be viewed as something special, a kind of frosting on the cake. The teacher who is unable to integrate family life education throughout the child's whole learning experience is an anachronism in a day when we pretend, at least, that we are no longer teaching the Three R's but are truly preparing young people for living . . . living fully and richly.

Teacher-Training To Insure Stable Family Life

Whatever the faults of our colleges in their preparation of teachers, school administrators can do something to remedy the situation by in-service training for their own faculties. Such training cannot be either provided or absorbed overnight. But immediate steps must be taken

if we are to meet the problems of sexual delinquency, broken homes, divorce and sexual promiscuity in the next generation. Our own generation reflects some signal failures—failures on the part of many parents, many churches, many schools. Whether or not we accept the statistics of Dr. Alfred Kinsey without qualification, they certainly point to previous failure to provide young people with true understanding of the place of sex in the scheme of things.

Two enormously important members of most school faculties—the school nurse and the health educator—and their contributions to family life education have not yet been mentioned. This has been deliberate for it seemed essential to attempt first to clarify some of the basic questions in regard to the role of the school in such education.

The Role of the Health Educator

The health educator is all too often expected to assume the total job of sex education and all too often does assume it without recognizing the basic fallacy in the premise on which he is expected to operate. The health education curriculum is far too heavily loaded with the physical and the factual to be the ideal vehicle for sex education. There can be appropriate integration of some aspects of such education into the health education curriculum (just as into social studies, literature, home economics), but that should be the limit of the health educator's classroom responsibility.



*The health
educator—
a faculty
adviser.*

On the other hand, we have scarcely begun to see the true extent of the health educator's potential contribution as adviser to the faculty, as an aide to the curriculum planners and revisionists.

The School Nurse

The school nurse undoubtedly has a contribution to make, of a similar nature. She also has a splendid opportunity, if prepared by training

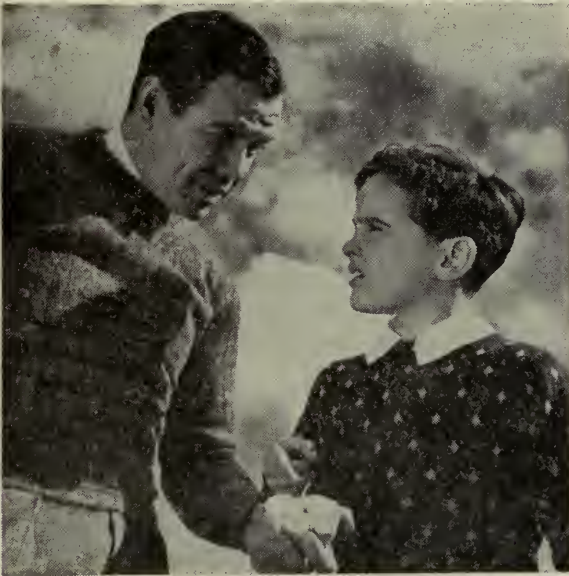
to grasp it, to serve as a special consultant to anxious, worried children who need individual conferences in this field.

But the use of the school nurse's services in providing a course in family life education is an immediate denial of the principle of integration. It places such education in the very category of specialization in which it does not belong.

Many school nurses have made remarkable contributions to parent education in this field, to curriculum planning and teacher education, to the individual child who needs and seeks help. Administrators should no more expect the school nurse, however, to undertake the entire job of sex education than to expect the health educator to do so. Each has a part to play; neither constitutes the cast of the performance.

The Home, the School, the Church

Basic to the whole question of the role of the school in sex education is the need for parental understanding of parents' own responsibilities.



*Daddy,
how can
a seed
make
another
apple?*

There is need for parents to understand just what it is that the school views as its share in this mutual home-school educational effort. There is need for guidance from the churches on moral training. In short, there is need for the three major influences in the child's life—home, school and church—to work as a unit . . . as partners in an important and profitable enterprise.



AN APPROACH IN SCHOOLS TO EDUCATION FOR PERSONAL AND FAMILY LIVING

by the New Jersey Department of Education's
Advisory Committee on Social Hygiene Education

I. Introduction

The New Jersey Department of Education's advisory committee on social hygiene education has revised its earlier publication, *An Approach to Sex Education in Schools*, which was No. 1 in a series of bulletins on education for family life. The original pamphlet, prepared in 1940 by the New Jersey Social Hygiene Association's education committee, was published in 1941 by the American Social Hygiene Association.

When the New Jersey Social Hygiene Association disbanded in 1942, its education committee was invited by the State Commissioner of Education to become an advisory committee to the State Department of Education. With changes in membership from time to time, the committee has continued to the present. Dr. Mabel G. Leshner, the American Social Hygiene Association's educational consultant, has been the chairman since its organization and has given tireless and devoted leadership.

One of the committee's first activities was to study the needs in New Jersey in the field of sex education. They found that there was a public demand in many communities for the schools to assume more responsibility in preparing children and youth for effective home life.

Furthermore, a questionnaire-survey revealed that many school administrators also believed the schools should set up a more adequate program of sex education. Seventy per cent of those who replied to the questionnaire agreed that more emphasis should be placed on this phase of education.

Since the 1940 survey young people and the public in general have increased their demands for education for family life. The New Jersey Congress of Parents and Teachers has consistently promoted better understanding on the part of its members by holding regional institutes on family life education and by making social hygiene education for family life one of the local Parent-Teacher Association goals in program planning.

At their annual meeting in 1948 the New Jersey Congress of Parents and Teachers passed a resolution asking that New Jersey's teachers colleges prepare student teachers to give children sound instruction for good family living. The resolution also asked that provision be made for in-service training of teachers.

In an effort to provide helpful material for schools the New Jersey advisory committee prepared two other bulletins, *Education for Human Relations and Family Life on the Secondary School Level* and *Education for Family Life in the Primary Grades* (see the suggestions for reading at the end of this article).

The trend toward an increasing interest in sex education as part of the education of young people for normal living is not confined to New Jersey. The movement is nationwide. The American Social Hygiene Association is receiving more requests for help in education for family life than ever before.

II. What is Education for Personal and Family Living?

Youth faces many problems of personal and social adjustment. Those growing out of the sex factor are among the most difficult and vital. An understanding of sex and its meaning to the individual and society is therefore an important part of education for personal and family life.

Education for family life aims to preserve the family and to improve and enrich family life. In fact, this is one of the goals of all education. Contributions to such a general aim are the main purpose of any planned program of education for family life.

Such a program never is narrowly conceived and limited to information about reproduction. Of far more importance than such facts are

the attitudes children develop toward each other, toward the role of father and mother in family life, and toward their own personal and social relationships and responsibilities.

An Unbroken Program

There is no one place in the school program to which a course in family living can be limited. It is a continuous part of the educational program from kindergarten through high school. For example, in the kindergarten the school can, by planned activities, share in helping children develop wholesome attitudes toward the relative roles of the mother and father in the family, toward themselves as individuals who share and contribute to family life, and toward their relationships to other boys and girls.

In the seventh and eighth grades, children need help in understanding their own adolescent development and experiences, and in establishing their social relationships.

The senior high school has the opportunity to give students preparation for marriage in all its aspects, including parenthood and the care and education of children.

Each phase of the program contributes to the next. Indeed, the need for education for family living continues after high school and should be a part of college and adult education programs.

Interpretation of sex as a basic factor in mental and physical health and in personal and social relationships is a continuous challenge to all who want to help children grow up as well-adjusted human beings.

III. General Principles

- Education for family living is a responsibility of the home, school, church and community. Each supplements and reinforces the efforts of the others.

- Education for family life includes sex education as an inseparable part of the education of the total personality. Scientific facts are basic tools, but sound sex education is more concerned with the interpretation of facts, development of ideals and provision of inspiration than with formal instruction.

- Sex education is directed toward an appreciative understanding of the potential value of the creative force of sex in life.

- A well-integrated home, school, church and community program of education for family life helps children develop satisfactory attitudes, build up emotional controls and make richer contributions to the home and community.

*How to
-make friends?
How to
grow up?*



IV. What Can the School Contribute?

The foundation for family living is laid during the first years of an individual's life. Relationships of the various members of a family in the home setting have a profound influence on character formation. Definite attitudes and ways of behaving towards members of the same and the opposite sex are well established by the time the child reaches school age. His sense of security is largely determined by his experiences in the family group.

The person who said that the home is "the kindergarten of social relationships" was paying tribute to the importance of the home as an educational influence.

There is general agreement that the home carries the major responsibility for sex education. However, homes vary greatly in their adequacy to meet this need. Schools are in a unique position to help parents with this responsibility.

Strategic Position of Teachers

Teachers can supplement favorable home influences and counteract undesirable ones. They work with all the children of the community. They have many opportunities for guiding children. They work cooperatively with parents. They are in a strategic position to help a child develop an idealistic concept of family life based upon the part played by the father, the mother and each child.

Children in groups are not the same as children with their parents. When they discuss questions together, they find strength in "the binding of the group."

Other educational advantages the school has in supplementing the home include:

- Teachers have been trained to work with children.
- Group discussion tends to make the subject less personal and emotional.
- Audio-visual and laboratory facilities of the general curriculum afford natural approaches for instruction.
- Natural integration of education for family life in the curriculum of the elementary and secondary school obviates undue emphasis on sex as a separate phase of life.

Children are protected by correct positive information about themselves and their functions. Seldom does a child escape unwholesome sex information from such sources as partially or wrongly informed associates, vulgar street terminology, and objectionable pictures, printed material, films and radio programs.

Truthful information, skillfully presented, fortifies the child against serious damage from the threatening experiences that are bound to occur. It helps him build a philosophy of life which will counteract sordid influences.

There are innumerable opportunities in the present school program for giving instruction in family relationships from the kindergarten up. The youngest children can be helped to form wholesome attitudes which will assist them in meeting personal problems and will lay the foundation for sound marriage and family life.

The school has opportunities for working with parents on common problems. These opportunities include individual conferences and cooperation with parent-teacher organizations and other adult groups.



*Toddlers
learn to
like each
other.*

Every Teacher an Influence

Every person in the school system influences consciously or unconsciously the development of sex attitudes in the children with whom he associates, whether the policy is silence or complete and uncritical frankness. By bringing together these individual forces and harnessing them to a unified and purposeful plan, the lives of children and their present and future families will be enriched.

V. The School Program

1. The development of a school program of education for personal and family living needs community-wide support. This presupposes an understanding of the program by parents and community groups and endorsement by the school authorities.

In its approach the school must avoid the introduction of a hasty or ill-considered program because undesirable results may follow premature or untimely efforts. It may be necessary to omit or qualify certain phases of a proposed program in order to gain community support.

2. The approach to instruction should be positive and carefully planned. The positive aspects of sex should be stressed by giving children an appreciative understanding of the important role that the creative force plays in both individual development and social relationships.

3. The school program should be introduced in the nursery school or kindergarten and continued throughout twelve or more grades as an integral part of the school's contribution to character-building.

4. The program should be developed by the school staff and integrated within the curriculum. Natural opportunities for teaching are afforded by science, health, physical education, biology, home economics, English and the social studies. Considerable functional instruction can be interwoven into the recreational and social programs of the school.

Talks by outside speakers are not advocated because of the danger of presenting the subject as an isolated part of life rather than as a normal phase of everyday life.

5. Adequate recreational facilities should be developed as a part of education for family life. Undesirable recreational facilities too often contribute to an unwholesome conditioning of the child in his present and future family and sex adjustments.

6. No course in the curriculum should be labeled *social hygiene* or *sex education*. These terms should be used only to indicate to teachers and parents that definite parts of the education of young people are being directed toward healthy, natural and wholesome relationships in life as they are affected by sex.

VI. A Teacher's Qualifications

The personal and intimate nature of education for family life demands that a teacher be sensitive to all that is involved in human relations. A primary requisite is that the teacher be an emotionally mature person. The attitudes and reactions of children will be influenced more by the personality of the teacher than by all of the facts that may be presented.

Other desirable teacher qualifications are:

- Belief in the need for this type of education and in the teacher's opportunity to assist young people constructively in making fine adjustments in their family situations and in their relationships with members of the opposite sex.
- A sound emotional attitude toward sex—an attitude in which sex is accepted as a normal factor in life, without minimization or exaggeration of its importance.
- The ability to maintain a sympathetic understanding of the problems of young people and experience in dealing with these problems.
- A faculty for inspiring confidence and aspiration towards high ideals without seeming sentimental or preachy.
- Respect for differing ethical, legal and religious views and for progressive scientific knowledge.
- Knowledge of the various aspects of sex and the ability to interpret that knowledge according to the physical, psychological and social needs of the children.
- An understanding of the place of education for family life in the entire curriculum and familiarity with suitable methods of integrating it throughout all school experiences.



*What to tell them?
Consider their
physical needs, too.*

*Sex or clay—
she takes them
both for granted.*



VII. Study Opportunities for Administrators, Teachers, School Nurses and Parents

Until qualified teachers are available in sufficient numbers to develop a complete program of integrated instruction from the lowest to the highest grade, a partial approach may have to be made, especially in the secondary school.

In some schools integration has been started by capable teachers in the fields of science, home economics and health education. In other instances courses in education for family life on an elective basis have been successfully introduced by one or more qualified instructors.

Only two states (Oregon in 1945 and Michigan in 1949) have made instruction in this field compulsory by law.

Successful demonstrations of education for family life on a small scale may have to be the first steps in the direction of a more far-reaching program when competent teachers become available.

On-campus and off-campus courses in education for family life have been offered in New Jersey by Rutgers University, state teachers colleges and other schools. Such educational opportunities extend back to 1934, when college credit courses were first given in Camden by Temple University's School of Education. In a few instances boards of education, the New Jersey Congress of Parents and Teachers and some

local Parent-Teacher Associations have underwritten the cost of study for members of their respective groups.

Since 1941

Opportunities of becoming better prepared to make constructive contributions to family life education have increased tremendously since 1941. Many teachers colleges include instruction in this field as a part of the curriculum requirements for all students.

Other forms of study vary from organized workshops and college courses with credit on the undergraduate and graduate level to forums, one-day institutes and special speakers on the subject. There is a trend for children to participate in some of the study groups, thereby making their personal needs and interests known to those on whom they depend for guidance.

Publicity should be given to the opportunities for study that exist in each state. Information can be obtained from your State Department of Education, state university or other key center of education and from the American Social Hygiene Association.



SUGGESTIONS FOR READING

Books

Bibby, Cyril.

Sex Education—A Guide for Parents, Teachers and Youth Leaders. Emerson Books, 1946. Teachers find this very helpful on all levels.

Biester, L. L., Griffiths, W. and Pearce, N. O., M.D.

Units in Personal Health and Human Relations. University of Minnesota Press, 1947. Most complete and helpful guide on the secondary level.

Bullis, H. E. and O'Malley, E. E.

Human Relations in the Classroom. Hambleton, 1947. Demonstration of applied mental hygiene in the classroom.

Fink, E. M. and Force, E. S.

Family Relationships—The Toms River Plan. Continental Press, 1946. Ten topics toward happier living presented to 12th-grade boys and girls.

Leshner, Mabel G., Robbins, Samuel T. and Snow, W. F.

Education for Family Living. Journal of Educational Sociology reprint, American Social Hygiene Association, 1949. A-765. A sampling of what is being done in four states and two community school systems.

Texas Board of Education.

Course of Study for Family Life Education. Mimeographed. Very complete, detailed course for 12th grade.

Strain, F. B.

Sex Guidance in Family Life Education. Macmillan, 1942. Written for teachers but valuable also for parents.

The Normal Sex Interests of Children. Appleton-Century, 1948. Many elementary teachers and parents find this helpful.

Your Child—His Family and Friends. Appleton-Century, 1943. Fine on personal relationships in the home and outside world. Practical discussion of day-by-day problems.

Wetherill, Gage G., M.D.

Human Relations Education. American Social Hygiene Association, 1950. Describes the program in the San Diego schools.

Pamphlets

American Social Hygiene Association.

A Formula for Family Life Education. Content, habits, tastes and attitudes children should acquire during pre-school, elementary, junior and senior high school years. Invaluable for teachers and parents.

American Social Hygiene Association.

Education for Human Relations and Family Life on the Secondary School Level. Subject matter, courses and topics for integration with various subjects.

American Social Hygiene Association.

Parent-Teacher Guidance in Social Hygiene Education for Family Life. Excerpts from *Biology of Sex* by Thomas W. Galloway. The philosophy, time and manner of instruction, graded projects and problems in sound guidance of children and youth.

Leshner, Mabel Grier, M.D.

Meeting Youth Needs. New Jersey Congress of Parents and Teachers, 1945. A practical guide for parents and for leaders of discussion groups on the social hygiene phases of parent education.

New Jersey City Supervisors of Home Economics.

What Is Family Life Education? Ruby Jane Abbott, Ridgewood High School, Ridgewood, N. J.

AUDIO-VISUAL AIDS

Audio-visual aids should be used to stimulate further interest in a subject. They should provide a basis for discussion. They should not be considered ends in themselves nor should they be expected to tell the whole story. All visual aids should be previewed before using and careful preparation made for their introduction and discussion.

Films

A Family Affair.

22 min., sound. Problems of average American family—should mother make dates for children? New York University Film Library.

Are You Ready for Marriage?

18 min., sound. A boy and girl are helped to plan before becoming engaged. Coronet Instructional Films.

Baby Meets His Parents.

11 min., sound. Baby's personality as influenced by parental attitude. International Film Bureau.

Emotional Health.

22 min., sound. Proper attitude toward an emotional upset. McGraw-Hill.

Families First.

22 min., sound. Four basic requirements of every child—security, affection, recognition and new experiences. An excellent film to introduce the subject of sex education. New York State Department of Commerce.

Feeling of Hostility.

28 min., sound. How a girl compensates for her failure to win needed affection. McGraw-Hill.

Feeling of Rejection.

22 min., sound. Case history of girl who later achieves self-reliance. McGraw-Hill.

Human Beginnings.

A film by the Eddie Albert Productions.

Human Growth.

19 min., sound, color. The original "Oregon film," presenting facts of human growth and reproduction.

Human Reproduction.

21 min., sound. Presents human growth and reproduction in the family situation. McGraw-Hill.

Make Way for Youth.

20 min., sound. Community cooperation with young people; intergroup attitudes. Association Films.

Shy Guy.

15 min., sound. Shows how a high school boy learns to make and enjoy real friendships. Helpful in discussing personality development. Association Films.

Addresses of Film Distributors

American Social Hygiene Association
1790 Broadway
New York 19, N. Y.

Association Films
35 West 45th St.
New York 19, N. Y.

Bertram Willoughby Pictures, Inc.
1600 Broadway
New York, N. Y.

Coronet Instructional Films
Coronet Building
Chicago 1, Ill.

International Film Bureau
6 N. Michigan Ave.
Chicago 2, Ill.

March of Time Films, Inc.
369 Lexington Ave.
New York, N. Y.

Text-Film Department
McGraw-Hill Book Co., Inc.
330 W. 42nd St.
New York 18, N. Y.

New Jersey State Museum Film Library
Department of Education
State House Annex
Trenton 7, N. J.

New York State Department of Commerce
40 Howard St.
Albany 7, N. Y.

New York University Film Library
26 Washington Pl.
New York 3, N. Y.

Princeton Film Center
Princeton, N. J.



PROGRESS AND TRENDS IN SEX EDUCATION IN THE UNITED STATES

by Josephine V. Tuller
Director of International Activities
American Social Hygiene Association

In the International Union Against the Venereal Diseases, we have devoted ourselves for many years to the fight against syphilis and gonorrhea, killers and cripplers both and enemies of all mankind. Until now we have given our time and thought largely to public health and medical measures against them, with results of which we are all proud.

Now, however, we are going beyond discussions of case-finding and diagnosis and treatment to consider the problem that lies at the root of most cases of venereal disease: sex conduct. We can accept it as a fact that if sexual promiscuity can be lessened—if human sex conduct can be modified—as much and more will be done to wipe out the venereal diseases as has been done by the distinguished medical scientists in all the laboratories, all the clinics, all the hospitals of the earth.

An Interpretation for Friends Abroad

Presented in May, 1951 at a joint meeting of the International Union Against the Venereal Diseases and the French Society for Sanitary and Moral Prophylaxis

Before reporting on progress and trends in sex education in the United States, it should perhaps be pointed out that there are great differences between the cultural patterns of any two countries: differences developing out of geographical location, history, religion, neighbors, literature—all the tremendous experiences of national life.

The United States—Land of Infinite Variety

Therefore, perhaps you should be reminded that we in the United States have something of almost every other culture in our own. We have been called, and rightly, a melting-pot of peoples. The men and women who came from distant lands to live here brought with them their own cultures, their own ways, to the great enrichment of the whole. As the years go by, our people become more and more homogeneous, but they still retain an infinite variety of ways of doing and thinking, variations that are nearly as broad as those between nation and nation.

Thus it is natural to expect that a wide range of reactions will be made to proposals concerning any educational program. Any program

*They love
Grandmother's
stories
of the
old country.*



recommended by the American Social Hygiene Association (as the national voluntary leader in the field of sex education) or by the United States Office of Education (as the national government agency concerned) or by any of the other national voluntary and official agencies which participate in our country's educational efforts, is subject to numerous modifications. Our state and city departments of education, our universities and colleges and the more than 200 state and community voluntary social hygiene societies in our 48 states have specific ideas about the modification or change of any proposed program.

These diversified elements have necessarily given to the social hygiene movement in America broad experience since 1904 when Dr. Prince A. Morrow founded the New York Society for Sanitary and Moral Prophylaxis. Nearly 50 years ago this society was dedicated to the theory that education, interpretation and understanding about the place of sex in life have an essential role in shaping human health and happiness, and especially in preparing children and young people for maturity.

Pinpointing the Personal

In looking beyond the differences in cultural patterns, we find more and more similarities. A man belongs first to the human race, and he seeks health, happiness and peace, even as his neighbor. His search is an intensely personal one, and any group or organization wishing to help him reach his goal must understand that personal need. Therefore, this paper is written not from a collection of data on what is done and where, but rather as a running commentary of suggestions and explanations as to why and how certain programs in sex education are functioning in the United States.

Aims of Sex Education

In promoting the social hygiene movement in the United States, we recognize that our effort to influence sex conduct is most effectively advanced through training and guidance in childhood and youth. We speak of this long-range program as *sex education* or, since successful marriage and family life are intrinsically concerned with sex, we call it *family life education* or *education for marriage and family life*. Some call it *sex-character education* or *social hygiene education*.

Under any name the aims are the same:

- To guide the child, the youth, toward an understanding of his own sexual nature, the false fulfillment of promiscuity, the importance of home and family life.
- To help youth develop psychological and social, as well as physical, maturity as necessary integration for the founding of and membership in a family and in a society based upon the family.

The experience of the human race has taught us that this is the road to personal happiness.

These things are too important to leave to chance. If your son is going to be a doctor, you will see to it that he gets the best possible training for his future career. Whatever occupation he chooses as a means of earning his living, it is almost certain that he will be a husband and father, the founder of a family. And your daughter is equally sure to be a wife and mother, homemaker and housekeeper, first teacher of her children.

Our profound conviction in the United States is that we must educate for this basic career if living in the family is to be all that it can be as a richly rewarding human experience, as preparation for life. We cannot say that every good parent or every good citizen is what he is because he has been the fortunate recipient of sound sex education and guidance. We can venture to say, however, that more and better sex education will decrease the number of misfits, increase the number of happy families.

Adults Should Be Prepared to Teach

To fulfill these aims, guidance given to youth must be clear and true. Parents and all others who share in the training of children and youth must not only know the facts about sex but must also be capable of imparting these facts in an unselfconscious manner.

American parents and teachers—and no doubt parents and teachers in other countries have somewhat the same difficulty—are apt to be both embarrassed and perplexed by this responsibility unless they have received some instruction in ways and means of teaching children about sex. In the United States this has led to the establishment in many communities of programs and courses for adult education regarding sex, marriage and family life.

*A good
home bears
good fruit.*



Help is available from a variety of sources. Parents and teachers often organize study groups with a competent leader, in which they consider the basic facts to be presented to the child and discuss the most effective manner of presentation. Father, mother and teacher may read books especially prepared to aid and guide them in fulfilling their responsibilities in this field. There are books for children too, about animal babies as well as human babies and about their mothers and fathers and their homes.

They may visit art museums, where paintings and sculpture show clearly and without comment the external differences between the sexes, and where the basic family group of mother and father and child is the subject of varied and sympathetic presentation by artists of many lands. On display in several of the popular scientific museums of the United States is an attractive series of bas reliefs showing the development of the fetus in utero and the birth process itself.

And out of doors there is all nature, with its endless illustrations of how life is carried on. Often the adult learns with the child.

Sex Education in the Home

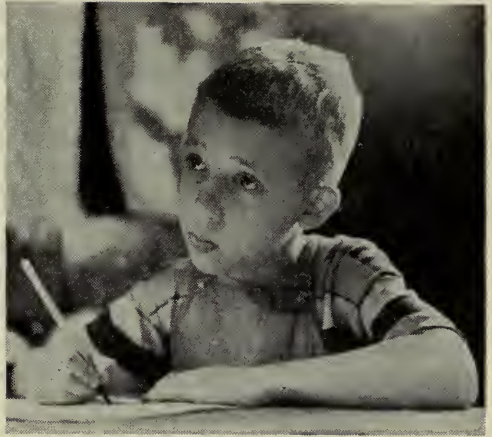
Parents are usually the first, and should be the best, of the child's teachers about sex-related matters as well as most other things in life. But the attitude of the whole family group from whom the child learns is important. Older sisters and brothers, aunts, uncles, grandparents, sometimes domestic servants—what they do and what they say, and how they say it become a part of the child's impressions and knowledge.

The child is a natural mimic and his imitations, both conscious and unconscious, of his parents and other members of his family are a significant and important part of his learning. A home in which the



*Today's
dates—
tomorrow's
families.*

*Why?
What?
How?
Give him
the truth.*



influencing action is loving, kind, responsible and wholesome will most likely produce a child who displays these same characteristics, even if at first they are not his own but merely imitations of his environment. In the same way, a home producing the opposite factors of hate, selfishness and carelessness will tend to produce a selfish, careless child.

Nothing can be of greater importance in its influence on character and preparation for marriage and family living than this early indoctrination.

It therefore becomes important that not only parents but all adults to whom the child looks for information give a thoughtful response. He asks, "Where do babies come from?" with the same open curiosity and lack of embarrassment that he feels when he wants to know, "What makes the thunder and lightning?" His right is to receive the most honest, informed reply of which the adult is capable.

If the child is scolded or silenced, he quite certainly receives the impression that there is something shameful about birth. If he is told an untruth, he will eventually find it out and conclude that whoever told him is not a reliable source of information on other matters as well as on this particular one. The only safe and fair answer is the true one.

American parents usually find that their children's first questions about sex occur during the three-to-six-year-old period, although sometimes as early as two years. At that age, the simple truth that babies grow inside their mothers' bodies usually satisfies the young inquirer. Later he will want to know more: how the baby came from the mother's body into the outside world, how the baby got inside its mother, and other details.

To each of these questions we urge parents to give frank and direct answers. If they will do this, without embarrassment, without mystery,

there will be no later need for correcting early myths about storks who bring babies swinging precariously in their long bills . . . about doctors who bring babies in their little black bags . . . about babies found in cabbage patches. These fanciful ideas, which no doubt exist also in other countries, have, alas, been common in the United States for generations, and we are only just now beginning to emerge from the confusion that they brought with them.

Children have no better memories than their elders. They often repeat the same questions, and in a way this is an advantage in teaching them about sex. By the time a parent has explained to a child for the third or fourth time the honest truth that babies are born of their mothers, parent and child are equally casual and unembarrassed.

A Workable Vocabulary

During the first years, when the little child's vocabulary is growing, is the time to teach him the correct names for the parts of his body, including the external sex organs. It is just as easy for him to learn the correct names for these organs and their functions as to waste his time on the foolish nicknames we adults have foisted on generations of children because we ourselves wanted to avoid sex-related words. Sound training now will save him embarrassment in adolescence.

Every child who has brothers and sisters or little playmates or who sees his parents in the informality of the home learns first-hand something of the differences in structure between boys and girls. Parents have an admirable opportunity in this connection to broaden his horizon about the social roles of fathers as breadwinners and of mothers as homemakers and to illustrate in simple terms the reason for and meaning of family life.

What About the Father?

When a child asks questions about the father's part in bringing a new baby into the world, it is sometimes difficult for his parents to answer, although not for the child to accept, because the former are self-conscious about sex relationships. He easily understands that every baby must have both a father and a mother and that each parent contributes equally to the making of a new human being. This leads naturally to the question of how this cooperation on the part of the parents is managed.

Children who live all or part of the year in the country are, of course, familiar from their earliest years with the mating of animals. They make the necessary analogy with the mating of human beings naturally and without shock. The movement of peoples of highly industrialized nations from the country to the city has immensely increased the need for sex education, because in the city animal mating is no longer a

commonplace. City parents therefore often rely on the mating of animal pets to inform their children about human mating.

The expected arrival of a new baby in the family gives parents an admirable opportunity to develop the story of human reproduction. Children should be told in advance of the coming birth of a new sister or brother and be prepared to welcome and love the new addition to the family. When the infant arrives, they will watch him nurse and attend the ritual of his bath and gain broad sex education thereby.

Thus, by everyday happenings in the home and family circle the child may be taught and the parents may also learn. Parents do not have to be equipped to present an elaborate discussion of human reproduction in answer to children's questions. Little children could not understand such a discussion if it were given. It is honesty, simplicity, affectionate helpfulness that are needed here—not a seminar in biology.

We would all agree that parents, because of their special closeness to the child, must be and should be his first teachers about sex-related matters. That does not mean that as he matures they will remain his only teachers. The school with its organized course of instruction, the church with its special responsibility for moral guidance, social contacts that allow him to make friends with other boys and girls, books, magazines, films, plays, radio, television—all contribute to his growing fund of information about the relations between the sexes and the institution of the family, which is built on that relationship.

*We've a
new baby
at our
house!*



Sex Education in the School

Since by common consent we have delegated to the school the task of carrying forward from age six or thereabouts the formal, organized preparation of the child for adult living, we must at this point consider the role of educational institutions in the progress of his preparation for marriage and family life. In the past our schools have planned their curricula as education for earning a living, as an enrichment of life through introduction to the best of literature and art, as character training. All these things the school must certainly do.

But in presenting courses of study designed for such purposes, the well-trained teacher, working within an agreed-upon framework, can profitably widen the child's horizon so that it takes in more and more of the great story of birth and growth, love and marriage and parenthood, the meaning of family life.

We in the United States are still studying the primary school curriculum to discover how it can best serve these ends. We have only rather recently come to a working agreement on what the secondary school's role in sex education is and may be. There is a sound reason for this order of progress: by the time a young person enters secondary school, he has reached adolescence. The tremendously important fact of approaching sexual maturity is affecting his whole life, his body, his emotions. This is a crisis in his life, and the schools, we believe, should not fail to help him pass safely through that crisis toward emotional maturity.

In the early days of sex education in the United States, school authorities who were concerned about the tragedies of illegitimate pregnancies and venereal infections called in physicians to lecture to the boys at one session and to the girls at another. We believe that was and is quite the wrong way to go about sex education. The clinician, the surgeon, the public health worker, the laboratory man are not *primarily* teachers, and this task is an educational one calling for all the skills of the well-trained pedagogue.

This does not mean, however, that we advocate simply substituting a teacher for the doctor on the raised platform before an uneasy group of embarrassed boys or girls. On the contrary. We think that the isolated single lecture on sex-related topics is useless and even harmful.

Credo

We believe that sex education (using that term in its broadest sense) should become an integral, organic part of the entire educational program. We are trying this system out in the United States in many communities and, while it is still a relatively new development, results indicate that we are on the right path. We still have to do a major

*A single
lecture won't
prevent the
baby on the
doorstep.*



job of preparing teachers for their role in presenting this integrated program. We still have to interpret it intelligibly to the larger public, although recent public opinion polls indicate that a majority of parents in the communities studied welcome it. We still have church groups who are fearful of its effect on morality, but we believe that fear stems more from unfamiliarity with the integrated program than from any basic disagreement on principles.

The Integrated School Curriculum

Science. Some biology is taught in our secondary schools, either as a separate course or as part of a more general science course. The student learns about the single cell and about cell division, the simplest form of reproduction. Building on this introduction to the origin of new life, the student goes on to study higher and more complex forms of life, with their microscopic and macroscopic differentiation between the sexes. In the impersonal and investigatory atmosphere of the laboratory and classroom, where there can be no reason for embarrassment, he gains an increasingly well-based understanding of all life processes and a vocabulary that clothes his understanding with words.

Literature. The student is introduced to both the classical and modern literature of our own country and to that of other peoples through

language courses. By telling the story of men and women and of their relationships to one another and to the society which they have created, literature serves as the personal history of the world, of what men learn from it and contribute to it, and as such it cannot fail to educate young people for adult living, including the great adventure of love, marriage and parenthood.

Health and Physical Education. In our secondary schools we have courses in health and physical education by that or a similar name. Here young people learn to understand their bodies and how they function, how to protect them from disease and other injury. In our opinion their study of the serious communicable diseases should include information about syphilis and gonorrhea, just as it should include information about tuberculosis, trachoma, typhoid and all the other ills that man is heir to.

The venereal diseases should never be singled out for special attention nor be treated in any but a thoroughly factual scientific manner. Instruction should cover method of transmission, causative organism, diagnostic procedures, treatment and the results of lack of treatment—never illustrated, however, with any of the old-fashioned horror pictures and stories once the stock-in-trade of health education pioneers.

Home Economics. The secondary schools of many countries give home economics or domestic science or homemaking courses in some form for



*They know
how their
bodies work.*

the benefit of girl students. Schools in the United States where an integrated program of sex education is in effect make a conscious effort to train for marriage and parenthood as well as for housekeeping, cooking and sewing. They discuss the origin of the family, instruct in child care, bring little children into the classroom to give interest and practical application to the lessons. In recent years boys have asked to enroll in such courses, an indication that the courses are supplying something youth needs and wants.

Social Studies. Still another course that can contribute to a growing understanding of the role of sex in life is the one we call social studies. Here students discuss the family as the basic social unit, the home relationship, the status of women, attitudes toward children, law as it affects the family, morality, customs, the community as an aggregation of families, the nation built upon the fellowship and cooperation of millions of families.

Students review history to enrich their understanding of man as a social being. They study community, national and international institutions and organizations. All this study contributes to their growing understanding of the world they live in.

Sex education is, of course, simply a part of character education, the development of the adult personality, of an integrated social being. That is a big task and one in which we need the informed assistance of our educational institutions.

The Role of the Church in Sex Education

As a young person meets the sex-related problems that come in the process of maturing, he needs wise counsel, good advice, someone to talk to about things that are disturbing. His parents are there to help, but frequently he needs to turn to someone outside the family circle, someone who can look at his problems with the perspective that comes from a certain degree of detachment, someone who can view the particular in the light of the universal.

No one should be better trained or more experienced in meeting these ever-recurring problems of all mankind than the clergyman—priest, pastor or rabbi. He is in a strong position to interpret the moral code to young people, to speak to them with all the great authority of the church. Our spiritual leaders, if they are wise men, know that human beings are fallible and need spiritual help and guidance if they are to meet and overcome the temptations of adult life.

In recent years many of our churches in the United States, concerned as all churches everywhere must be with the well-being of the family, have added to their function of spiritual leadership certain educational and interpretive functions by organizing formal courses of instruction and discussion groups for young people approaching the age of marriage.



*They know
there's more
to marriage
than frosting.*

Group Discussions

When young people are beginning to think of founding families of their own, the time has come when group discussions under a competent leader have much to contribute to an understanding of the origin of the family, the history of human marriage (differing in externals, perhaps, from nation to nation, but always the same group of mother and father and child, a permanent entity recognized by the community and by society as a whole), love between the sexes as a specifically human contribution to the relationship of male and female, love of and responsibility for children, mutual trust and sympathy and understanding between marriage partners, companionship—all the things that make a good marriage and a good home.

Let us emphasize two points:

- Since the church is an indispensable part of the family-school-church triumvirate sharing the responsibility for preparing youth for life, churches need to give serious thought not only to their own role in this joint undertaking but also to that of the family and the school. Having given the objectives and methods of this great task their blessing, they should go further and give it their active support.

- If the clergyman is going to carry his full share of the program, he should have special training in seminary or theological school to enable him to do so.

The Role of Youth Groups

The young human being who is growing up feels a strong pull towards those his own age. His elders are too conservative, he feels. His juniors, still engaged in the noisy games of childhood, are no use to him whatever. But his own generation understands him, knows how he feels about things, what worries him, what he wants to do and be. With his peers he can talk endlessly—and a very considerable part of that talk will be about love and sex, particularly the opposite sex.

Youth organizations in the United States have begun to build upon this universal interest by forming discussion groups and providing trained leaders to guide them. "What qualities are most important in a husband?" ask the girls, who proceed to answer their own question in their several ways. "What does one want in a wife?" the boys ask themselves, and go on to describe the girl of their dreams. Sometimes both boys and girls of the same age meet together to talk about such questions as "What makes a happy marriage?", "At what age should one marry?", "Is money important to marriage?", and so on.

It is quite possible that no conclusions new to their elders are arrived at in these discussions, but they do have the very real value of directing the thoughts of young people through the moonlight and roses of romantic love to the solid ground of marriage and family life that lies beyond.

Trained leaders for such discussion groups are provided by the agencies sponsoring them. Ideally, these leaders should give the talk free play, merely suggesting a point of view here, bringing the discussion back to first principles there, supplying accurate information at another point. There are not nearly enough such competent leaders now, but youth-serving organizations are giving thought and impetus to their training. They have a very real role to play in a broad program of preparation for marriage and family life.

Public Health Aspects of Sex Education

It is a curious and interesting circumstance that the venereal diseases, the enemy which we are banded together to vanquish, are transmitted from one individual to another primarily by sex contact. That fact leads to its inevitable corollary: we, as public health workers, must be concerned with human sex conduct. We all know that sexually promiscuous persons are those most likely to be venereally infected and to spread their infection.

Sex education, which has as its first objective the orientation and stabilization of the individual with regard to the tremendously powerful sex drive, tends to decrease promiscuity and so to limit the spread of the venereal diseases. Sex education therefore makes a very real and substantial contribution to the public health. It should not, in our opinion,

be undertaken *primarily* for its public health values, but those values exist and must logically be in the forefront of our thinking about it.

Attack the Source

Let us go back now to the first principles that have led the International Union Against the Venereal Diseases to give its time and thought to a consideration of sex education as a training for life. Syphilis and gonorrhea are more than serious communicable diseases. Since they are primarily spread by promiscuous sex contacts, their very existence is an indication of faulty attitudes toward sex and marriage and family life.

We have two choices in this situation:

- To continue everlastingly to search for and treat existing cases of venereal disease, spending our time and our energy and our money, our penicillin and our other miraculous drugs in an attempt to cure.
- To attack the problem at its source, in sex conduct itself.

No one who has given serious thought to the problem can fail to come to the conclusion that we should dedicate ourselves to an attack at the source, at the same time using every medical and public health measure at our command.

Bibliography

A Formula for Family Life Education. Prepared by members of the American Social Hygiene Association's committee on education. 5¢.

The American Social Hygiene Association—What It Is—What It Does. Free.

The American Social Hygiene Association—Some Notes on the Historical Background, Development and Future Opportunities of the National Voluntary Organization for Social Hygiene in the United States, by William F. Snow, M.D. Free.

An Approach to Sex Education in Schools. One of a series of bulletins on education for family life prepared by the New Jersey Social Hygiene Association's education committee. 10¢.

Dating Do's and Don'ts for Girls. 5¢.

The Common Ground in Family Life Education. A symposium on points of agreement and emphasis among the three major religious faiths. 20¢.

Education for Family Living. A symposium on general trends and work in progress in various school systems and communities. 40¢.

Education for Human Relations and Family Life on the Secondary School Level. 15¢.

Education for Personal and Family Living as Applied to the Social Hygiene Field. A report prepared by members of the American Social Hygiene Association's education committee. 15¢.

Living with Our Children, by Evelyn Millis Duvall. 5¢.

Marriage Education in the Colleges, by Henry A. Bowman. A summary report of a study conducted under the joint auspices of the National Council on Family Relations and the American Social Hygiene Association, 1948-1949. 15¢.

Parent-Teacher Guidance in Social Hygiene Education for Family Life. Excerpts from the book, "Biology of Sex," by T. W. Galloway. 35¢.

The Role of the American Social Hygiene Association. Free.

Sexual Behavior—How Shall We Define and Motivate What is Acceptable? Papers and notes from a panel discussion. 25¢.

Sex Education in School Programs on Health and Human Relations. 5¢.

Sex Education—One Phase of Human Relations, by Lillian B. Davis. 10¢.

Sex Education in the Home, by Helen W. Brown, M.D. 10¢.

CREDITS

McGraw-Hill Text Film Photograph, p. 49.

Sex Education in the Schools. Ohio's Health, Ohio Department of Health. September, 1951, p. 49.

County Coordinating Council, San Diego, Calif., p. 51.

Acme Photographs, p. 56, 63.

A Walter Watson Photograph, courtesy of Parents' Magazine, p. 59.

Prudential Insurance Company of America, Newark, N. J., p. 60.

Ralph Overstreet Photograph, by permission of the Society for Promotion of Nursery Schools, p. 63.

Carl Iwasaki Photograph, by permission of Time, p. 64.

Bulletin, Kentucky State Department of Health, p. 68.

Pitt Photo Library. Photograph by Libsohn, p. 69.

Pitt Photo Library. Photographs by Corsini, p. 71, 73.

Community Chests and Councils, p. 72, 75.

Pitt Photo Library. Photograph by Bubley, p. 78.

Recent ad in the New York Times, November 13, for the Health Insurance Plan of Greater New York, 7 East 12th St., New York 3, N. Y., p. 80.

Eliese S. Cutler, p. 87, 90, 92, 93.



Announcing a New Publication—

PRE-INDUCTION HEALTH EDUCATION MANUAL

From outlines used by schools during World War II, Mrs. Esther Emerson Sweeney, ASHA's director of community service, and Roy Dickerson, executive secretary of the Cincinnati Social Hygiene Society, have developed a Pre-Induction Health Education Manual. Its purpose: to help young people prepare in advance to meet the demands made upon them by the times in which we live.

Several schools are using the manual on a test basis this semester. A revised version—ready for general use next fall—will incorporate their modifications.

The editors have arranged the test edition in units for a 12th-grade, two-semester health education course, but others may wish to condense the material or to integrate it throughout every grade. In any case, the manual is a flexible guide for both teachers and youth leaders—including social workers, ministers and club leaders—who have the job of encouraging the physical, emotional and social growth of those who will soon enter service or defense plants.

With an eye to the stresses and strains that today's adolescents will inevitably face, the manual emphasizes:

- * Good understanding and management of human emotions.
- * Physical fitness for military service or defense work.
- * Sound relationships between the sexes.
- * The false propaganda of the prostitution racket.
- * The value of service in the Armed Forces to the individual boy or girl.
- * Common situations in which young men and women will find themselves.

The manual's editors obviously feel a prepared youth will be less susceptible to the temptations of new environments, freedom from parental supervision and the different moral standards of unfamiliar companions than one totally unprepared for new and trying experiences.

The manual considers the place of sex in human life from the point of man's obligations to himself and to God. It contrasts the hazards of extra-marital sex relations with the deep satisfactions of the marriage bond.

A short quote from the section on personality—specifically the social aspects—reveals how concretely the manual develops a point and stimulates pupil thought.

"The group in which the individual moves sets up many standards of behavior and patterns of conduct. In his dress, the individual follows the group, often even when such attire is unbecoming or displeasing to him. His attitudes towards the moral code will reflect those of his parents and his church, in the main, but may reflect, too, those of the social group in which he grows up. Hence, the necessity of helping young people to sort out what is morally binding upon them from what is merely a matter of social custom in their environment.

"Class Discussion

"When should you have the courage of your convictions, regardless of what other people think?"

Questions for class discussions, suggested class activities and references follow immediately after expository material and point up the lesson in terms of the young person's experience.

The table of contents lists chapters on the use of the manual; the efficient management of personal living in the national emergency; mental hygiene; physical health and fitness; spiritual health and development; social hygiene for boys and for girls; a social hygiene supplement which is an additional unit of basic facts, including those about human reproduction; the young women in the defense program; and the young man and the Armed Forces.

The Pre-Induction Health Education Manual is based on lasting principles and proved ideals. In war or peace, whether used in toto or selectively, it will serve as a dependable source of material for all who are interested in guiding youth toward a worthy maturity.



*A square
marks the
area of
operations.*

VENEREAL DISEASE CONTROL IN SOUTHEAST ASIA

by John C. Cutler, M.D., M.P.H.
United States Public Health Service

On the basis of my experience in India and Afghanistan, I shall attempt to outline here the venereal disease problem in southeast Asia and the steps taken by the governments concerned and by international organizations to bring about control.

A Dearth of VD Data

In 1948 the World Health Organization announced that a venereal disease demonstration team would be available for the southeast Asian region, and the government of India requested its services.

A survey of control activities in India at that time showed that accurate statistics were scarce and the existing data could do little more than suggest the extent of the venereal disease problem. In Madras, admission data collected from clinics and hospitals indicated the seriousness of the problem in that area. Records of the medical department of the Indian Army provided some information on incidence in one group.

No other significant figures were available, since venereal diseases were not required to be reported by states and provinces to the central govern-

ment. Nevertheless, informed workers were agreed that the diseases were highly prevalent. Here are some of the facts pointed out when the request for international assistance was made.

Obstacles to VD Control

In Calcutta, Bombay and Madras, municipal venereal disease clinics had been in existence as long as five to ten years. But the pioneer workers behind these clinics were facing the same stalemates that had earlier been faced in the United States—lack of public and official interest and support; scarcity of funds, supplies and equipment; and too few trained personnel.

In spite of these handicaps, the Calcutta VD control system in 1949 reported approximately 35,000 new admissions to its clinic and had established a separate, small hospital. Typically, the load was so great in relation to the existing medical resources that only about half of the first admissions could be given even a single qualitative serologic test for syphilis.

Conditions were similar in Bombay and Madras.

Even the fundamentals of a control system were lacking in the great majority of cities and provinces. Consequently, venereally infected individuals were handled by governmental clinics and hospitals along with other patients. Or, if financially able, they went to private practitioners.

The shortage of physicians, drugs and diagnostic facilities was, and in many places still is, so severe that many patients with early infectious lesions were turned away because diagnosis and treatment could not be

A school house substitutes as headquarters.



provided. Hospital beds available for venereal disease patients were generally used only for those with late manifestations of the diseases.

At the present writing, there are only about 12 laboratories in India routinely handling 200 or more serologic tests for syphilis each week. The shortage of supplies and antibiotics remains critical throughout the country.

Headquarters of the WHO Team at Simla

As recommended by the WHO's Expert Committee on Venereal Infections, a demonstration team was assigned to the government of India to establish a suitable system of control in both an urban and a rural area and to give instruction in those methods of diagnosis and treatment which might best be adapted to local resources. WHO provided a group consisting of a physician, serologist, public health nurse and health educator with health education equipment, as well as supplies for a diagnostic laboratory and for clinical activities.

The government of India provided funds for a matching team, for supplies and equipment available locally, for some drugs and medicines and for transportation. In addition, the Indian government agreed to continue activities started in venereal disease control following withdrawal of WHO assistance.

The province of Himachal Pradesh, where syphilis was known to be endemic, was selected as a site of operations. This province had recently been formed though the merger of some 30 of the former princely states in the Himalayan foothills northwest of New Delhi and extending in some places to the Tibetan border. The area is mountainous, communications are difficult, the population of about one million is extremely poor, and the medical services are very meager although being expanded as rapidly as possible.

Good hospital facilities and a laboratory were found in Simla, which is the largest city although part of another, more highly developed province. This one laboratory served not only Simla but also the province of Himachal Pradesh for the serodiagnosis of syphilis as well as other clinicopathologic work.

Not more than 40 samples of blood per month had come through the laboratory for testing for syphilis. No organized system of care for venereally infected patients had existed in the region.

Headquarters for the WHO team was consequently established at Simla. The matching team was assembled, a special laboratory and an outpatient venereal disease clinic were set up, programs of routine testing and treatment were instituted in the male and female hospitals at Simla and in the municipal prenatal clinics, and a survey program to determine the prevalence rate of syphilis in this and other regions was begun. A training

program for physicians, laboratory workers and nurses—first from the immediate region, then from other parts of India and surrounding countries—was started.

In the first 17 months, 29 persons had completed training, and control activities in at least seven hospitals and clinics in Himachal Pradesh and elsewhere in India had been initiated by some of the trainees.

High Prevalence of VD

The survey activities revealed certain clues to the prevalence rate of venereal disease. In the Himachal Pradesh region it has been known for many years that much syphilis and granuloma inguinale existed, but no statistics were available.

The survey indicated that

- About 50% of the adult population in the Ghund territory of this province had a positive serologic test for syphilis.
- In the entire Himachal Pradesh province (a very small part of India, incidentally) the prevalence rate among adults in rural areas was never found lower than 15%.
- About 27% of the adult male hospital admissions in Simla were found to have positive serologic tests.
- The lowest prevalence rate in the region, 4%, was found among the upper middle-class pregnant women from urban Simla, but they are not representative of the district.
- In New Delhi, rather large samples from the male hospital population and from prenatal clinics showed a rate of about 12%.

These figures served to indicate the vast amount of the disease requiring treatment in the surveyed areas.

Granuloma inguinale was found to be highly prevalent in the Himalayan foothills region. From 10 to 15 of the 100 hospital beds available in Simla for females were usually occupied by patients who required long periods of hospitalization for granuloma inguinale because most of them required surgical intervention after years of having had the disease.

Gonorrhea apparently occurs less frequently than does syphilis or even granuloma inguinale. The reason for this is not known, but the much higher ratio of syphilis to gonorrhea in the Indian troops had been noted during the last war.

Clinical Manifestations of Syphilis

Aortic insufficiency, tabes dorsalis, optic atrophy, meningovascular syphilis, and gummata were the observed late complications of syphilis,

but no figures as to such prevalence can be given. Since the life expectancy in India is approximately 30 years, the average individual hardly lives long enough to develop the later complications.

In both India and Afghanistan I observed many patients with late secondary manifestations. I rarely saw the early primary lesion, because the patients usually tried indigenous or home remedies first and sought medical attention only if the lesion persisted or progressed.

It was interesting to observe the familial spread of syphilis in patients attending the clinics in Herat, Afghanistan. Families of 10 or more individuals, ranging from the grandfather of about 80 years of age to children of two or three years, all showed signs of early infectious syphilis, apparently transmitted asexually throughout the group as in the manner of bejel.

In the children, the clinical signs of secondary syphilis were, to me, identical with those described as bejel, which occurs among the Bedouin tribesmen and their families living under much the same conditions in the Middle East. In this observation, confirmation was given by Dr. F. Akrawi of Iraq, who has attempted to show identity of the two diseases by human inoculation.

Treatment—Lack of Drugs

The routine treatment used by the demonstration team for early and latent syphilis consisted of a single injection of procaine penicillin in oil with 2% aluminum monostearate.

The distribution of medical services in many southeast Asian countries is necessarily conditioned by budget limitations. It is important for the



*Bagain
school
children are
examined.*

public health worker to consider how to get the greatest benefit for his health district out of a pitifully small stock of drugs and supplies, particularly penicillin and other antibiotics. For instance, if a health department has funds for 1,000 cc. of penicillin for syphilotherapy, a single-injection schedule of 1 cc. per patient would "cure" about 60% of early syphilis cases brought to treatment, or about 600 individuals. A schedule using 2,400,000 units (or 8 cc.) of penicillin would cure perhaps 90% of treated patients, but 1,000 cc. would provide initial therapy for only 125 persons.

- It is evident then that under such conditions factors other than cure rates must enter into the consideration of public health measures to be adopted.

The private physician is not necessarily so limited in his management of patients financially able to pay for treatment, since his responsibility and services may be more narrowly confined to the circle of his clientele. Nevertheless, the use of any penicillin schedule in underdeveloped areas, such as are found in India and Afghanistan, must be based on the availability of the drug.

Penicillin is not yet made commercially in these countries and must therefore be imported and paid for from the "hard currency" reserves of the governments. Thus, the choice of therapeutic schedules in public health work must be based upon what is practical for the country and not upon what is considered ideal in the United States, where abundant supplies of drugs and resources are available.

Inadequate Laboratory Facilities

An earlier reference was made to the relatively small number of laboratories doing even a moderate volume of serologic testing for syphilis. I am convinced that any effective program of venereal disease control needs good laboratory resources.

In India a few large centers were found to be well equipped for serologic testing, but they were seriously understaffed and handicapped by lack of supplies. In most of the cities facilities were woefully inadequate as to both equipment and trained technicians. In one large governmental laboratory I found the bottoms of neoarsphenamine ampules being used as Kahn tubes. Not infrequently a hospital laboratory would be found to have no more than one or two pipettes to do not only serology but also the clinical chemistry.

Aware of the paucity of equipment, technicians and funds for supplies, the members of the WHO team in Simla set up the simplest testing procedures possible compatible with a reasonable degree of accuracy. After experimentation the team selected two slide tests which provided

accurate, rapid and inexpensive serologic testing without requiring a high degree of technical skill as compared to a more complex procedure such as the Wassermann test.

A training program for technicians was instituted as soon as laboratory procedures had been decided upon.

Local Prejudices

Poverty, illiteracy, superstition and religious beliefs were additional factors which influenced the organization of the control program. For example, in a strictly orthodox country such as Afghanistan a physical examination of a female by a male physician is almost impossible. One of the leading venereal disease workers in Afghanistan had never been able to perform a complete physical examination on a female in 11 years of medical practice. In India, only after long explanation would the average woman submit to examination by a male.

In some areas, local traditions hampered the physicians' complete examination of even the males.

Also, many patients did not fully understand the nature of their infection.

Our experience in Simla taught us that it was often worth while to take some time to gain the patient's confidence and to teach him a little about his disease. By this means we could secure his aid in bringing his contact for treatment, if he or she lived not too far distant.



*Up the hill
to Ghund.*

*Centrifuging
blood samples
compete with
the camera.*



Transit Is Not Easy

Distance and time are extremely important considerations in regions where the medical services are sparsely distributed. Patients not infrequently walk from 10 to as much as 200 miles to reach the nearest physician. The implication of this factor with respect to getting all patients to come to early treatment, not to mention the performance of contact-tracing and follow-up, is very clear.

Even in big cities such as Bombay a farmer or laborer will often have to walk long distances for treatment and will usually require a full working day to make one clinic visit, thus losing wages which he can ill afford to lose. Under such circumstances, the patient deserves and needs to have diagnosis and treatment expedited as much as possible.

However, rapid and accurate diagnosis and immediate therapy are difficult to obtain, since the physician in an average clinic will often have to see and dispose of as many as 100 patients in one day, in addition to taking care of his small hospital. It can be understood why he has no opportunity to do more than quickly observe the patient and carry out the treatment immediately necessary.

These illustrations are offered not in the spirit of criticism but rather as typical of some of the difficulties faced by public health workers in these and similar regions. The physicians are aware of and eager to adopt the resources of modern medicine and new diagnostic and therapeutic methods. What is needed to increase their efficiency and to expedite their work are simple, accurate laboratory procedures requiring a minimum of technical

execution and equipment and the simplest applications of modern therapeutic advances which can be utilized.

It should again be pointed out that in planning and evaluating programs for these countries, it is necessary constantly to keep in mind their particular needs and resources and, above all, the desires and temperament of the people themselves, and to base all decisions on these facts rather than solely upon American standards, experience and level of acceptance of medical care.

There is in India and Afghanistan a tremendous reservoir of venereal disease which needs treatment and which must be approached from a public health point of view. What has been said with respect to this group of diseases can be applied equally to almost all other widespread diseases in the regions. Efforts are being continued by the health services of the countries involved, by international groups such as the World Health Organization and by direct and indirect American aid. But the problems to be met are great.



*The author, who was
formerly leader of the
World Health Organization's
Venereal Disease
Demonstration Team
in Simla, India.*

Partners, Not Patrons

I am convinced that most of the public health workers in southeast Asia have an appreciation of their problems and needs and welcome aid. But this statement is true only if the international worker comes into an area with a real desire to serve in partnership with the medical profession of the country—rather than with the idea of doing the job alone or merely advising on how public health measures should be carried out, without considering the progress made locally and the social, scientific and political problems of the region.

Having seen the response to the WHO programs, I feel we have proof that programs begun with outside aid can and will be absorbed into the regional health services and will significantly contribute to their effectiveness. A strong demand for better public health exists in the articulate segments of the population of these countries and should be met with aid from outside groups for the mutual benefit of all the peoples of the world.

BOOK NOTES

The Camp Counselor, by Reuel A. Benson, M.D., and Jacob A. Goldberg. New York, McGraw-Hill Book Company, 1951. 337p. \$4.50.

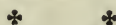
Part of a series on health education, physical education and recreation, this text is designed for future counselors, camp libraries and camp staffs.

The selection of counselors on the basis of personality, character and training, and camp organization largely determine the quality of leadership in the 6,500 American children's camps and the extent to which the physical, mental, emotional, social and moral needs of campers are met.

Legal provisions, health, emotional and personality problems are considered, and it is emphasized that deep-seated personality or behavior deviations cannot be adequately solved by the counselor.

The chapter on social hygiene stresses that the counselor must familiarize himself with the parents' concept of sex instruction if he is to avoid later misunderstandings in the children's homes. The counselor needs to know what sex problems will arise and what can be done about them. He must never forget the over-all activities that contribute to health and good character and social growth, the children's and his own.

A summary, a list of questions and answers and suggested assignments follow each chapter, and comprehensive appendices complete the volume.



The Science of Health, by Florence L. Meredith, M.D. Philadelphia, Blakiston Company, 1942, 1951. 452p. \$3.75.

Intended for college hygiene courses, this edition includes new material on vitamins, antibiotics and current statistics.

The first section is concerned with a general picture of national health and the human body. Other parts of the book cover more specifically the maintenance of health, major health problems, mental health and the next generation.

A section on syphilis and other venereal diseases briefly outlines the symptoms and treatment and makes the startling statement that mortality from syphilis is estimated to be 100,000 annually.

"The Sex Impulse" discusses love and marriage, the denial of sex and the reasons for such continence, emotional fixations, dealing with sex impulses through the conventions, substitution and sublimation.

Following chapters on reproduction and heredity and parental care are a bibliography and index. Amply illustrated, the text covers a good deal of ground and can be easily understood by the average undergraduate.

THE LAST WORD

"There is no question that the goal of democracy will be achieved eventually whether it takes one hundred years or one thousand years. The real question is whether the promise of democracy can be achieved quickly enough in the face of the great difficulties confronting the world to prevent countless years of needless human misery.

"Fortunately in this country our problem of fully realizing the promise of democracy—equal opportunity and the good life for everyone—is not dependent upon the acquisition of greater natural resources or the achievement of a higher level of technology. It is dependent solely upon our ability as fellow-Americans to cooperate with each other in making certain that every American citizen really does have an opportunity to lead a personally satisfying and socially useful life. In other words, our problem is one of finding ways and means of developing the necessary social organization, not one of finding the economic resources to carry out our social aims."

—ARTHUR J. ALTMAYER, Commissioner
Social Security Administration

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journal of SOCIAL HYGIENE

vol. 38

march 1952

no. 3

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About our cover . . .

WOJG Davis S. Abe, Mrs. Abe, Lisa Jo and Jeri, U. S. Army family in Japan. Mrs. Abe was formerly with ASHA's international division. Twelfth of a series of Journal covers on family life.

Harriett Scantland, Editor

Elizabeth McQuaid, Assistant Editor

Eleanor Shenehon, Editorial Consultant

THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

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sunday morning with the smiths

reflections on the double standard

It was Sunday morning in the Smith home. Mrs. John A. Smith was serving her family slices of golden toast as fast as they popped up from the toaster.

"John, I can't tell you how pleased I am with this new toaster. Every slice is evenly browned, nobody gets a burned piece. No bread is wasted," Mrs. Smith said.

"An impartial toaster, I'd say." John fancied himself a wit. He chuckled while his family continued to munch toast.

Fourteen-year-old Tom looked up. "Yeh, the toaster's impartial. But that's the only thing. In other things we have a double standard. For instance, Dad, everybody goes to church in this house except you. Can't I skip church and play golf with you for once?"

John straightened himself. "Religion and all that—that's all right for women and young folks. My job is breadwinning. That's what I'm doing on the golf course—working up a deal with a couple of business acquaintances."

"Another fast deal like the one you pulled last week, Pop?"

"That deal was entirely legal, Tom. You wouldn't understand until you get into business yourself. It's a man's world and everybody's out to make a dollar. It's dog eat dog—there's no law against it. Well, got to get going."

Mrs. Smith's plain, earnest face was growing pinker by the moment.

"No, that isn't all, John." She looked uncertainly at the children. "Children, will you please go outside? I want to talk with your father. . . ."

Mrs. Smith had recently joined the National Council of Women, and the little scene just related brought back forcefully to her mind some of the points she had heard at a meeting.



*A baby needs
affectionate care.*

The speaker had given a rousing talk about moral welfare being a man's concern as well as a woman's. Although Mrs. Smith was no feminist, believing as she did that a mother's place was in the home, she nevertheless thought that a father had something besides a financial stake in that home.

She would be the first to admit that women had more opportunity to foster ideas and practices of morality within the home than had men. Didn't they spend far more time with their children? She could see her own conscience reflected from time to time in the decisions her children made. She knew instinctively that the choices her children were making, under her guidance, would some day influence the vastly more important choices they would be making as adults. She could visualize thousands of women like herself molding indirectly the decisions that would be made by the next generation in business, in the great national and international councils.

It was an inspiring thought, but it was not enough. Women alone could not do the whole job. They could not be considered the sole custodians of personal morality, chastity and honesty — of social morality, marital fidelity and family stability — of public morality, business and political ethics.

Indeed, it was not enough that moral influence be a woman's job. The father must exert a moral influence, too, in the lives of his children. Only

through the partnership of both men and women in the home, later in the school and in society, through the cooperative effort of each, could a single standard of morality, of broad social concern, become a guiding force in the lives of the new generation.

These vital thoughts had been revolving in Mrs. Smith's mind for several weeks. Let it not be said that they occurred to her at the actual moment the toast popped out of the impartial toaster.

It takes cooperation.



That Toast Again

But that toast did set them in motion. It had a single standard of excellence that the whole family could enjoy. Not a golden piece for the women and a charred one for the men. Mrs. Smith knew it was just as ridiculous and infinitely more tragic for the world to hold out to women the bright standards of chastity and honesty and to men a second standard, a second-rate one, of sexual immorality, business dishonesty and international deception.

Take that "fast deal" that John had pulled the other day. He had saved his firm thousands of dollars, gained a promotion for himself, accepted many impressive slaps on the back from the "big guns." "Good boy, John." "A smart one, that John Smith, a comer." That's what his associates were saying.

He had come home with big plans — a bigger house, better schools for the children, more exclusive clubs. The end justified the means in John's eyes.

But not in Mrs. Smith's eyes. For a moment John couldn't understand when his wife protested that the deal was unethical, that it was actually stealing thousands of dollars that belonged to another.

The end didn't justify the means, neither for John Smith nor for Joe Stalin. Whether the rights of business or of the state superseded the rights of the individual—it was all the same. It was still a violation of the moral code.

"Martha, you're a woman, protected, naïve about business. You don't know there are two kinds of honesty. In business we know how far we can go to stay within the law. If we get caught, that's hard luck. It's all in the game. You just stick to your knitting and we men will take care of the business world."

Mrs. Smith wasn't convinced. It was just what the speaker at the meeting had been talking about. John left the upbringing of the children exclusively to her so that moral education in her home became a lopsided thing, lopsided in actuality and in the minds of the children.

Far from helping her to give the children firm principles of honesty, John was actually tearing down the wobbly structure she herself had built . . .

Tom had listened to every word his father had said, questioned him about the legal loopholes, jokingly referred to "a fast one" he was going to pull on that nice, unsuspecting Allan Wilson next door.

For a moment John had hesitated. "Well, Allan's a friend of yours, isn't he? It wouldn't be sporting, would it?"

And quickly Tom retorted, "Were you sporting when you copped a few grand yourself?"

There wasn't anything John could answer. Tom sensed that his father had failed him but wasn't sure just *how*. What he needed was a 14-carat father all the way through, not a tarnished silverplated one. He needed a father who could give him an example of integrity in little things and big things, who could set him straight when the double-dealings of others perplexed him.

And the Children's Future?

Mrs. Smith looked dumbly at her son. Someday Tom too might be a father like John, seeking only to accumulate material things instead of building a happy family life within his own home, where his children could look to him for guidance.

Then Mrs. Smith looked at Jean. Already she regarded her father as a kind of giant bank account. For her, he did not exist unless she wanted money for something. Suppose she should carry over this attitude into her relations with her husband. There would be no affection, just tolerance and demands. What kind of family stability would there be in that home?

The prospect wasn't inviting. But neither was Tom's present dilemma. John had only succeeded in confusing his son, because his own standards were confused, illogical — it was the old double standard again, one for your friends, your women, your own country, another for business associates, men, other countries.

*Security, affection, loyalty—
within the single standard.*



The trouble was that the more you violated the code, the easier each violation became and the weaker was the code itself. If you picked and culled from the code, decided that "Thou Shalt Not Bear False Witness" was perhaps pleasanter to obey than "Thou Shalt Not Commit Adultery," which was a little severe, then you would destroy the code and hopelessly confuse your children. You could never be sure they would exercise the same discrimination that you had exercised. Perhaps they would prefer "Thou Shalt Not Kill" and scrap all the rest.

Already Tom was undecided about "Thou Shalt Not Steal." If only John could be uncompromising, could back up her own efforts. But he'd say millions of people had never heard of the Ten Commandments. He'd say you can't base a broad system of morality on a code unknown to millions of the world's people.

Everybody, Everywhere

Mrs. Smith remembered the words of the speaker. All nations — regardless of religious differences, — accept the idea of the existence of God, of man's possessing a soul, of free choice, of individual responsibility to God and man. Mankind everywhere recognizes the evil in murder, in theft, in sexual immorality, although the definitions may differ to some extent. If mankind is to maintain its dignity, apart from the irrational animal world, all of mankind, men and women, must accept the divine and human reasonableness of a moral code and must demonstrate that reasonableness to each other, to their sons and daughters, to states and nations.

It had been a fine speech, Mrs. Smith decided.

But a moral code wasn't the only answer. People needed information if they were to conform intelligently to a moral code. Mrs. Smith realized that the young, especially, needed sex instruction reinforced with strong moral convictions if they were to survive the insistent, all-pervading sexuality of the times.

You couldn't supervise adequately their dating activities, you couldn't shut out the movies, television, the ads, literature — you couldn't be an anachronism.



*Children have to live
their own lives.*

You could only give the young a firm foundation of facts, reasons, ideals, of good example. And then you trusted . . .

Little Cathy Gibson, who lived around the corner, had a good upbringing, a fine home, loving parents. She had lacked only facts. Mrs. Gibson often had boasted that she was going to keep Cathy a child as long as she could. Well, little Cathy, with the best intentions in the world, was completely bemused with the worldly wisdom and glamour of 18-year-old Dave West. Somehow or other her previous moral training seemed completely divorced from her tremulous new experience.

Cathy had no understanding of the role of sex in life, in family relationships, in self-discipline and responsibility. When her Sunday School teachers tried to relate personal responsibility to sexual responsibility, Cathy had no background of facts to tie these ideas to.

Mrs. Smith felt sorry for Cathy, whose disillusionment left her resentful and rebellious, defiant of any authority, incapable perhaps of someday enjoying a stable family life of her own. Mrs. Gibson couldn't see where she herself had failed.

Mrs. Smith worried particularly about her Tom. Would the lack of a father's sustaining influence and friendly advice leave him as footloose and confused, as amoral as Cathy? John, of course, had shirked his duty, had relegated sex instruction completely to his wife. It was another of those "women's provinces."

She felt that although sex instruction should be primarily the parents' responsibility (she had attended adult education classes to get concrete help and instruction), the schools had a complementary job to do in rounding out the work of the home. With the knowledge and consent of the parents, the schools should integrate family life education throughout the curriculum, emphasizing ethical and moral principles.

That Red-Light District

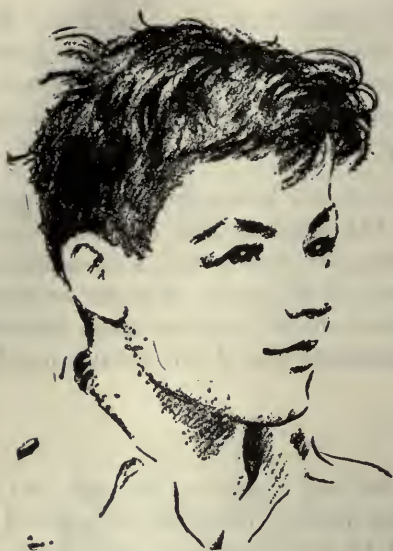
Her community too had a share in the task, but its interest was as difficult to win as was John's. Her idealism, practical and tenacious as it was, was frustrated by the *laissez-faire* indifference of her town to the implications of a flagrant red-light district that children passed on their way to school. Her women friends sniffed delicately when she broached the subject, talked about something else. Her husband said flatly that women like her could not walk about alone without such a safety valve. The community — from the mayor, the city council and the police down — ignored the situation, and protection money was alchemized into pretty suburban homes and family cars.

Mrs. Smith had heard her son asking John what the score was, saying that the fellows were talking one day about the district. She listened to John's evasive answer that could only rub off a little more of the adolescent idealism Tom was slowly losing. Even 10-year-old Jean looked wise when the subject came up.

Already Tom was confused by the easy tolerance of respectable people, of the whole community and its leaders. What kind of tolerance would he develop in a few years with the easy accessibility of that district? It might not be just an impersonal tolerance . . .

Only at her National Council meetings had she heard anything that resembled her own convictions about the matter. Here, especially at the meetings that touched upon international conditions, she learned that there were few countries in the world that did not have community conditions of casually sanctioned vice. It was the old double standard all over again.

Prostitution with its accompanying disease was a grave threat to family stability. She knew of one family which broke up because the husband considered his predilection for prostitutes one thing and his love for his wife another. And she knew, through her volunteer welfare work, at least one wife who turned to prostitution to support herself and her



Say, Dad, what's the score?

His father doesn't know.

family. Now two daughters were following their mother's lead — exploiting the town's youth, being exploited themselves by their clientele, their underworld associates and even by the police, who closed their eyes, for a price.

Mrs. Smith knew that there was a lucrative international traffic in women and girls that kept the venereal disease rates high in country after country, that debased the worth of womankind, that made a mockery of love within the home.

What Has Been Done

The International Council of Women had already taken steps to erase this threat to individual morality and family solidarity by urging their separate governments to sign the Convention for the Suppression of Traffic in Women and Girls. This had been passed by the General Assembly of the United Nations in 1949 and had already been signed by India, South Africa, Israel, to mention a few countries.

Mrs. Smith knew that these were only the first steps in a tremendous task that would involve convincing not only the women of the world, but the men, of the necessity for eradicating this human exploitation.

How better to convince them than to point out the tangible, undeniable results of sexual immorality, the physical and mental crippling effects of the venereal diseases? To show how the endless family problems arising from the physical and moral disabilities of VD victims broke down family stability, led to more promiscuity, completed one revolution of an unceasing circle.

To cement the work of the International Council of Women and the International Union Against the Venereal Diseases, two resolutions had been proposed with the twin purposes of eliminating VD and prostitution. Mrs. Smith had read the resolutions . . . in fact, she had read them twice and heartily concurred with them. If each nation could clean up its own backyard, then work with other nations in a general clean-up, the whole world would be sharing in the task of bringing morality into the family and into the national and the world picture.

From Acorns

Mrs. Smith sensed that this whole international problem could be solved only if each individual took some share of responsibility. If other wives couldn't get any more cooperation from their husbands than she got from John, the whole plan would break down.

It was still Sunday morning at the Smith house. The children had just been sent out, and Mrs. Smith was sitting flushed of face, her camel's back broken by John's bald-faced declaration that the dog-eat-dog policy of business justified his "fast deals." All the curiously mixed, resentful and altruistic thoughts of the last few weeks needled her into a declaration of her position.

Now was the time, golf date or no golf date, for Mrs. Smith to turn to a new page in her book, to explain what she stood for, to give him a glimmer of what she meant by sharing.

The pink slowly receded from her checks, the anger left her, and with a calm born of desperation, she went to work.

*No golf for Mr. Smith
this Sunday morning.*



Postscript: With a right good will, Mr. Smith accompanied his family to church.



by Louise Bates Ames

SEX BEHAVIOR AND SEX INTEREST IN CHILDREN

How To Tell Your Child About Sex

"How shall I tell my child about sex?" you parents ask time and time again. You seldom ask, "How shall I tell him about war?"—though war, to our way of thinking, is much harder to explain than sex. Nor are most of you too stumped about how to explain the nature of the universe, though that, again, seems to us a more difficult task.

So our first suggestion to you might be to try to think of sex as an unembarrassing, natural subject about which you are really qualified to speak. Realize that here is a field in which the chances are that you know the answer to any question your child may ask. Which is probably not true in the fields of relativity or atomic warfare, which do not, we suspect, worry you half as much as topics of discussion.

Feel, if you can, confident and unembarrassed. Believe in yourself. Not what you say but how you say it is what will really influence your child.

Second, let the child's own questions be your guide as to what you tell. There is probably no safer rule.

If you give only what information the child asks for, and for the most part give it only when he asks, you will avoid that greatest error of all—telling too much too soon. You also will be fairly sure of a receptive audience, since the child is not likely to ask unless he wants to hear the answer. His questions can be your guide as to how much he is ready to hear.

A third suggestion is not to read too much into the child's questions. Don't let your own more detailed knowledge of the subject lead you to believe that he wants to know all the details, when often a very simple answer would suffice.

There is the well-worn story of Eddie, who asked his mother where the new boy next door came from. Mother made the most of this opportunity to tell Eddie a few things she thought he should know about babies, and childbirth, and the father's part in the whole process. She was quite taken aback when Eddie commented, at the end of her long story, "Oh, he said he came from New York, but I didn't believe him."

Lastly, do not make the mistake of thinking that you have given this kind of information once and for all. Perhaps here more than with any other topic, the child asks and asks again. And you will need to answer over and over again, with increased elaboration and detail as he matures. It may not be so much that he forgets what you say as that, as he grows older, the same questions (and the same answers) mean different things to him.

Information which may have gone over the head of the 4-year-old may make sense to the five. So just because you have given a piece of information once, don't check it off your list. You may need to tell the same thing half a dozen times.

Giving Sex Information

"Why is it dark at night?"

"What makes the train go?"

"Where do babies come from?"

All these are among the questions your 4-year-old will ask you. And in all probability his questions about sex and babies are to him no different from his questions about other things. If we, as adults, could match the child's matter-of-fact unembarrassed attitude about sex, we would find it easier to answer his questions, and would probably do a better job of it.

Typical of the average child's matter-of-factness about sex is the answer one 5-year-old girl gave to a friend who asked her, "Are you old enough to have a baby?"

"Goodness, no," replied the little girl. "I can't even tell time yet."

It is important in giving sex information to avoid bewildering the child. Often in our embarrassment we find ourselves talking around the subject, and confusing more than we clear up. When the 5-year-old asks, "Where do babies come from?" what he wants to know is that they grow "in mommy's tummy." If we use such words as "seed" and "egg," we may make him think of gardens and chickens and may merely confuse him.

Her questions
tell you what she
needs to know.



"What was your mummy telling you about just now?" a little boy asked his friend.

"Oh, some wild story about the birds and the bees," the friend replied.

For most children, simple direct answers to their direct questions are most effective. But there are some parents who find it hard to give direct answers, some children who find it hard to ask direct questions. If you find it too difficult to discuss matters of sex with your child, it may be best to provide him with books on the subject. "A Baby Is Born" by Milton Levine, "Growing Up" by DeSchweinitz, "Human Growth" by Lester F. Beck, and "The Stork Didn't Bring You" by Lois Pemberton are among the many good books now available.

Many authorities feel that you should give this kind of information yourself personally and not leave the child to read it from a book. Better, however, for him to read it clearly from a book than to hear a confused story from an embarrassed parent.

"And what if he does not ask?" you say. The chances are that if you have answered his questions about other things adequately, and have not adopted a hush-hush attitude about sex, he *will* ask. But, if you feel that your child is way past the age when he should be asking, check up. You will very likely discover that he already has found out what he wants to know elsewhere.

If not, tell him what you want him to know, directly if possible, through books or other people if you cannot comfortably do it yourself.

When To Tell About Babies

How best can you tell your child about babies, their source and production? Obviously in as straightforward and unembarrassed a manner as you can muster.

What to tell him? Well, you know the facts. And the child's own questionings will give you clues as to which bits of information he needs and desires.

But *when* to tell him may puzzle you a bit. We have found certain usual stages in the child's interest in and understanding about babies (as reported fully in our publication: Gesell and Ilg, "The Child from Five to Ten"). A brief summary of these usual stages may help you with the timing of information:

3 years: Beginning of interest in babies. Child wants family to have one. Child asks, "What can the baby do when it comes?" "Where does it come from?"

Most do not understand mother when she says the baby grows inside of her.

4 years: Asks where babies come from. May believe mother's answer that baby grows inside her "tummy," but may also cling to notion that baby is purchased.

Asks how baby gets out of mother's "tummy." May think the baby is born through the navel.

5 years: Interest in babies and in having a baby of his own; may act this out in play.

Re-asks "Where do babies come from?" and most accept "mother's stomach" as an answer.

6 years: Interest in origin of babies, pregnancy and birth. Vague idea that babies follow marriage.

Interest in how baby comes out of mother and if it hurts.

Some interest in knowing how baby started. Accepts idea that baby grows in mother's stomach and started from a seed.

7 years: Intense longing for a new baby in the family.

Knows that having babies can be repeated and that older women do not have them.

Interested in mother's pregnancy. Excited about baby's growth. Wants to know how it is fed, how big it is, how much it costs.

Interested in books about babies, such as "The Story of a Baby" by Marie Ets.

Associates size of pregnant woman with presence of baby.

Satisfied to know that baby came from two seeds (or eggs), one from mother and one from father.

8 years: Understands slow process of growth of baby within mother.

Wants more exact information as to where baby is in mother's abdomen. Confused by use of word "stomach."

Some girls may ask about father's part in reproduction.

Your child's ability to understand about babies may be a little ahead of or a little behind this "schedule," but this will give you an idea of about the rate at which his understanding will develop.



*To a child
a seed
is only
a seed.*

Sex Play

The child's interest in sex may be embarrassing, but it usually is not particularly devastating to you so long as it remains in the realm of pure theory. His questions about babies and about the relations of the two sexes to each other may embarrass, but they usually do not really disturb you.

When his interest takes the form of actual sex activity, however, your reaction may be less calm, and much more emotional. There is probably nothing which disturbs the mother of a young child more than to discover him taking part, with other children, in sex play — nor to hear of his activities along this line from other, indignant, mothers.

A knowledge of the customary stages of sex play in the first 10 years of life — which we have found to take place in perfectly normal, well-brought-up children — may help you to meet neighborhood sex-play situations calmly and without too much horrified surprise:

His friends and he
get together on sex.



2½ years: Child shows interest in different postures of boys and girls when urinating and is interested in physical differences between the sexes.

3 years: Verbally expresses interest in physical differences between sexes and in different postures for urinating. Girls attempt to urinate standing up.

4 years: Extremely conscious of the navel. Under social stress may grasp genitals and may need to urinate.

May play the game of "show;" verbal play about eliminating.

Calling of names relating to elimination.

Interest in other people's bathrooms; may demand privacy for self, but be extremely interested in bathroom activity of others.

5 years: Familiar with but not much interested in physical differences between sexes.

Less sex play and game of "show." More modest and less exposing self.

Less bathroom play and less interest in unfamiliar bathrooms.

6 years: Marked awareness of and interest in differences in body structure between sexes. Questioning. Mutual investigation by both sexes reveals practical answers to questions about sex differences.

Mild sex play or exhibitionism in play or in school toilets. Game of "show." May play hospital and take rectal temperatures.

Calling names, remarking or giggling involving words dealing with elimination functions.

Some children are subjected to sex play by older children.

7 years: Less interest in sex.

Some mutual exploration, experimentation and sex play but less than earlier.

8 years: Interest in sex rather high, though sex exploration and play is less common than at six.

Interest in peeping, smutty jokes, provocative giggling; children whisper, write or spell "elimination" or "sex" words.

9 years: May talk about sex information with friends of same sex.

Interest in details of own organs and functions; seek out pictures in books.

Sex swearing, sex poems, beginning.

It is very important to keep in mind that usually none of the children who take part at any of these ages in recurrent neighborhood sex play are to "blame." Sex play often just naturally occurs if several children are left together unsupervised, with nothing better to do. Giving them more supervision, or providing ideas for something better to do, will often prevent such behavior.

And, as you will note from the gradient, this interest in sex play tends to go in fits and starts. Ages when such interests are intense alternate with ages when there is relatively little such interest.

Individual Differences

Not only are there ages when sex interest is strong, but there are also children who are, by nature, much more interested than others in the whole subject of sex.

There are the highly sexed children who show an early and intense interest, not only in asking about sex but in trying it out for themselves. There are others who show a very lukewarm interest in the whole topic and ask practically no questions. There is the intellectual type of child who wants much information early. There is the more practical type who asks few questions but finds out for himself.

There are some children who prefer the direct approach in all things. Such children want and need clear direct answers to their questions about sex. Others are not able to approach anything directly. They do best with a little information given late, and may be able to accept information about the sex activities of animals better than information about people.

There are the aware and the unaware children, the observant and the unobservant. This is not just a matter of intelligence. Some extremely intelligent children are quite unobservant about sex; other less intelligent, or younger, children are quite alert. The three Jones children — Eddie aged 6, Peter aged 4, and Patty aged 2 — had just been told about cats and kittens. Eddie was amazed, but Pete said matter of factly, "Always that way. Same thing with people, too. Don't you remember that mummy carried Patty in her stomach before Patty was born?" Pete, by nature, not by training, was interested in and observant about matters of sex. Eddie, though older, was not.

In regard to sex interest and sex behavior, as in regard to other things, children vary. You will do well to study your own child, find out what his response to sex is, and be governed accordingly.

Try to accept all the different stages through which the child passes as he learns about sex, and as he reacts to the opposite sex, with equal calm.

Interest in the Opposite Sex

This does not mean that you need welcome the occasions when your child indulges in sex play. Most of you, in our culture, will prefer that your children avoid such activity. But at least attempt to regard this behavior as calmly as you do other undesirable behavior — swearing at four, lying and cheating at six. Make no more and no less of it than you do of other lapses from the standards you choose to set up. Try to realize that it may be better for the child to show too much than too little interest in sex. Sex play at six is at least a sign that your child is developing normal sexual interests.

Patty was told
about cats and kittens.



Similarly when the child reaches the age of making smutty jokes, again you have the right to discourage such activity. But you should not be unduly shocked and distressed about it. Generation after generation it appears to come in, and subsequently in most children to drop out, as regularly as do the usual childhood diseases. Eleven and twelve seems to be a high point for smutty joking. It is unfortunate that the child's first strong interest in the opposite sex sometimes takes this seemingly unattractive turn, but there it is.

Sex play and smutty jokes may seem to you to have little relation to your daughter's first long dress, and her first formal party, or to your son's demand for the family car of nights. Actually, however, all of these things are part of a general growth gradient through which most children pass. First they are interested in the facts of sex and sex differences. Later they are interested in the opposite sex. But even here, in their interest in the opposite sex, they go through alternating periods of interest and indifference. And even these are a cause for worry in some parents.

Most, however, are calmer about this matter of interest in the opposite sex than they are in the matter of actual sex behavior. They view quite

calmly, or even with amusement and pride, the heterosexual activities of their 3-year-olds, some of whom even in the nursery school set up strong crushes. We remember one little boy who at the age of 3½ grew tired of his first "girl" and got another, and then didn't dare to turn up at nursery school for fear of what the jilted damsel would think.

Even through 6 and 7 years of age, in some cases twosomes continue to be frequent. And then comes a long bleak period. (It is not the "latent period" of which you all hear so much about which some of us have never actually observed.) Even here, interest in the opposite sex may be strong, but it is expressed in an interesting way. Girls and boys draw away from each other and profess to hate the opposite sex. A little boy of nine told us the other day, "Your book is all wrong. It says that boys of nine don't like girls but that they will like them again when they are 14. Well, all the boys in my class say they will *never* like girls again, and we treat them just as bad as we can just to be sure they will never like us."

This period, in its intensity, is extremely amusing to observe. Amusing because as adults who have once gone through it, we realize that if all goes well, your boy and your girl will emerge from it and many of them will go to the opposite extreme. "All she thinks about is boys," say the parents of teen-age girls. "All we talk about at the table is boys," says another parent. "Sometimes, though, we change the subject and talk about a different boy."

And here again, calmness on the part of the parents, especially on the part of fathers, is necessary. Growth does not proceed evenly, and often it does not proceed gracefully. Too much at one age, too little at another. But the knowledge that other parents are also suffering from this too-much and too-little, and a knowledge that it is the common lot of mankind to develop mature sexual abilities and interests through a long, complex and sometimes difficult series of stages may help you to accept tolerantly what goes on. Accept and perhaps even to welcome. Accept so calmly that by your very calmness you can help your child through this difficult series of stages toward a well-adjusted maturity.

Sex Education in the Teens

And how can we best give this help?

To very young children we give information about sex and babies in order that our children will have a basic fund of knowledge. We are interested in giving them facts. This is not, in most cases, too difficult.

But in the teens our problem becomes harder. Here we give instruction not so much to inform as to guide.

Shailer Lawton, M.D., in a recent authoritative but rather shocking publication, "The Sexual Conduct of the Teen-Ager," reports current

findings as to the too-free sex behavior of many of today's teen-agers. He lays the blame for much of the undesirable sex activity which goes on at this age to lack of knowledge and education. He quotes J. Edgar Hoover, who urges parents "to pay more attention to the sex education of their children."

We then face the question: What kind of sex information or education can we give our teen-agers which will be most effective? Here we may take a lesson from our own behavior when the child was younger. When your child was a preschooler you did not prevent sex play and experimentation by forbidding and objecting to it. You largely prevented it by providing other, more acceptable, interests.

Similarly, in the late teens you do not prevent undesirable sex activity by scolding, discipline or constant supervision. You prevent it by recognizing the realness of the sex drive in the teen-ager, and by providing the child with a view of himself and his life plan and life role which is not consistent with getting early sex expression and fulfillment. If this ideal is strong enough, it may help him to be willing to wait till his education is finished and until he is in a position to set up more mature sex relations.

It is helpful to many teen-agers if you can make them appreciate that sex relations involve a problem of responsibility as much as one of morality. And that in the teens most people are not ready to take on the responsibility which such relations bring.

LOUISE BATES AMES

Ph.D., Yale, 1936.
Director of Research,
Gesell Institute
of Child Development.
Co-author of
"Child from Five to Ten."



And lastly, you may ask yourself as parents, what is your ultimate goal in giving sex information? Is it just to inform? Probably not. Is it merely to help your child keep out of sex difficulties as he matures? No, it is more than that. Is it not to help your child to look at sex in such a way that he himself can one day grow up to lead a happy, successful and responsible sex life? If you keep this goal in mind, it will help you to know what to say to your child and how to say it.

FROM
BEHIND
JUDICIAL
ROBES



A Look at Divorce and Marriage Counseling

by Justice J. Allan Crockett

"May it please the Court," says Attorney Debonhair, "we would like to present a default divorce matter." Whereupon Mrs. Heesunkind, a comely woman of middle age, is sworn, takes the witness stand, and looks apprehensively about the courtroom.

Her lawyer asks the usual perfunctory questions: "Are you married?"—"Date of marriage?"—"Number of children?"—"Income?"—"Property?"—which she answers directly and with reasonable assurance.

Then comes the puzzler: "Now, Mrs. H——, you have alleged in your complaint that your husband has treated you cruelly, causing you great mental anguish and distress. Just explain that to the Court."

At this question, Mrs. H—— is definitely uncomfortable. She does not understand why it is necessary that she expose the details of her marital unhappiness to the court, its attachés and other curious spectators. But because she has been told that it is necessary, she bravely makes a try.

"Well, he speaks harshly and roughly to me."

"Yes, yes, go on," says Attorney D——.

She continues, "He is unreasonable and quarrelsome."

Attorney D——: "You mean he criticizes you before your friends and your family and treats you with contempt?" he asks helpfully.

"Yes, he criticizes everything I do or say."

The Court, having in mind the impersonal requirements of the law, asks, "Can you tell us some specific thing he does which you classify as cruelty?"

Mrs. H——: "Well, nagging for one thing."

The Court: "What does that consist of?"

Mrs. H——: "Well, just criticizing and quarreling with me and being displeased about everything."

Attorney Debonhair now resorts to some of the usual vague and almost meaningless generalities, which take various forms.

"Now, Mrs. H——, do you believe that his conduct is such that the legitimate objects of matrimony have been destroyed?"

"Yes."

"Do you believe that a further continuance of your marriage could only serve to make you ill and unhappy?"

"Yes."

A Triangle

The judge further questions Mrs. H—— for something tangible which could reasonably be supposed to cause her great mental anguish, but meets with doubtful success. Finally, Mrs. H—— leans towards the judge and says in a manner she desires to have seem as imparting to the judge some confidential information:

"The fact is, Judge, there is *another woman*."

With the situation thus so completely revealed to him, the judge smiles blandly, as though he understood the situation and agreed with the analysis. He grants the divorce, makes what seems to him and counsel the best adjustment with respect to the custody of the children, property rights, support money and alimony, and calls, "Next case."

The fact is that the judge understood it his way, Mrs. H—— understood it her way, and undoubtedly Mr. D—— understood it in an entirely different way, all perhaps worlds apart. To Mrs. H—— the real cause was the other woman, or it may have been "the real truth is, Judge, he is 'drinking' or 'gambling' or 'spends all his time away from home'" in pursuit of any one of those objectives or a combination of them.

A Web of Maladjustment

The judge, of course, is aware that the foregoing scene is the culminating point of what undoubtedly must be a very complicated set of

circumstances which not only he does not understand but, more important, the parties themselves do not understand; otherwise they might have had some chance of avoiding it. He must pause to wonder: Why did Mr. H—— turn from this attractive, apparently refined and personable woman whom he must have once loved and adored and with whom he had begotten and reared their children, built their home, and had, it would seem, every reason to continue to love and respect? Was it something in her attitude toward him?

It could be her own selfishness or lack of genuine interest in her husband and the family or absorption in outside things such as bridge clubs and civic affairs which was primarily responsible for their plight. Poor housekeeping, extravagance and too great a fondness for gossip, drink or other men are faults often blamed by spouses for domestic distress.

There is also the possibility that sexual maladjustment, differences in family background, intellectual capacity, education or religion are underlying causes of discord. And Mr. H—— may have been guilty of any one or a combination of these faults or their counterparts which caused her to develop whichever ones she had.

One thing the judge knows too well: The stark reality that the parties had become so maladjusted in their relationships with each other that either one or both could stand it no longer and so would rather seek divorce, with its even greater economic stresses, its social stigma, its loneliness, its bad effect upon the lives of their children—all those and more were better to endure than a continuation of the marriage which once promised only pleasure and happiness.

Just what could bring about the pressures necessary to make the parties face these new difficulties, the judge would like to know and remedy if possible. But he has not the time nor the means to find out. He must be resigned to the fact that by the time the case gets to the stage of formal presentation to the court there is little that can be done about it, except as Judge Paul Alexander of Cleveland has said, of divorce, "pronounce the benediction on the wreck."

Divorce No Panacea

If this consequence of marriage were the rare exception, it would cause us no great concern, but as everybody knows it is becoming more and more common. Even if we were wise enough to unravel the enigma of this individual case that would not be much of a contribution to the overall problem of divorce in our society. The steady and alarming increase in the divorce rate for each decade during the past 50 years is so well known as not to require detailing here.

It may be slightly reassuring to realize that this doesn't mean we have so many less family units. Perhaps about the same percentage of our

adult population is teamed up in marriage at any given time as formerly. Divorcees just keep on marrying, seeking that elusive entity, happiness. But unfortunately they carry with them from marriage to marriage the same basic personality defects and instability of character, so that they are rarely any happier in the next marriage than they were before. The number of family units in existence at a given time is not the vital thing. The alarming factor is the instability in them and the lack of security and other bad effects upon the children who are to make our next generation.



They need stable parents.

It is so obvious as to hardly justify comment that the family is the foundation of the social structure. Breakdown of family solidarity has run concurrent with decay in every decadent society in the history of our race. When the basic unit of anything disintegrates, what happens? By way of analogy, take any chemical substance, cause or permit disintegration of its basic unit, the molecule, and the substance no longer exists as such. Neither can the quality of society upon which our civilization is based continue without its molecule, the family unit. It should be plain enough without elaboration that every worthwhile social value is best served by a wholesome family life, where the parents and children dwell together in mutual love and respect and in the ideals common to our great religions.

If we agree, as it seems we must, that we are going in the wrong direction and that something must be done about it, we are led to inquire: How can the trend toward the wrecking of more and more marriages be arrested? If the divorce is the result of maladjustment of individuals in the marriage, the mass divorce movement is most likely a result of mass illness or maladjustment of our entire society. It will not be gainsaid that

the first step on the road to some rectification of the evil is to determine the real cause or causes if possible. What are they?

The Basic Unreality

It seems probable one of the primary difficulties is that our sources of information and means of communication have become so efficient they have outrun education, in its mature sense of learning to live with oneself and one's fellowmen. Since the movies, radio and now television are so generally available, and romance is the principal theme of every story, marriage itself is shown in distorted perspective. The glamour, the glitter and the sensual are played up out of all proportion to reality. What appears before our young people in this aura of romance seems to belie the necessity of the practical down-to-earth values of life.

It is small wonder that they are loath to burden themselves with such onerous undertakings as trying to learn skills and trades, becoming literate, developing personality, learning to cook, sew and keep house, when marriage is thus dramatized for them. Even the advertisements purvey the idea that if they will just use the proper shampoo and fingernail polish, romantic success will be insured, and if they choose the right brand of coffee, cereal and soap, they may live in luxury and effortless ease happily ever after.

Another part of this unrealistic picture is that divorce itself is represented as a casual, easy solution to be resorted to at the slightest rocking of the boat on the sea of matrimony. All this helps to make many of our young people ill-fitted to assume the challenging responsibilities of marriage and encourages them to shrink from trials and hardships, rather than to meet and conquer them.

The logical consequence of this whole shabby matrimonial scene is the way our lawyers and courts handle family difficulties in the main. This is understandable because our legal system only reflects the customs and attitudes of society. Its rules and procedures cannot create moral standards. Nevertheless, it has a responsibility, along with the rest of society, to effect needed changes to help correct this divorce evil.

Constructive Legal Reform

Our system of justice has inherent limitations in this field. It is often referred to as an "adversary system." It grew out of the ancient Anglo-Saxon procedure of trial by ordeal and trial by battle. In the latter, the litigant hired a champion to fight the opponent's champion to determine their dispute. The modern-day lawyer is the counterpart of the champion. The trial is a contest in which one side seeks to destroy (or discredit) the other and to preserve itself.

JUDGE J. ALLAN CROCKETT

*Law degree,
University of Utah.
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Adjustment Education.
Justice, Supreme Court of Utah.*



Setting aside any consideration of the merits or demerits it has for other phases of litigation, it does not seem to be suited to the purpose of serving the best interests of the family unit. This does not mean that the invariable objective in every case should be preservation of the marriage. Many divorces are necessary and in fact present the best solution both for the individuals and society. But the inquiry should be to find out the facts of the matter so that an intelligent analysis and adjustment can be attempted. Instead of a contest between spouses as to who is at fault, where each must seek to prevail by blaming the other for various frailties and misdoings (which only serves to inflame the passions and disgrace the spouses and their children), the inquiry should be calculated to minimize those things as much as possible, to emphasize the worthwhile affirmative factors, to enlarge the areas of agreement and concord, and thus tend to rebuild rather than to destroy the family unit.

Fortunately, during recent years, a great deal of progress has been made toward reforms in the direction of the courts' performing a curative rather than an entirely destructive function in cases of domestic distress. A number of states now have domestic relations courts operating separately from the courts in which other litigation is handled. In some instances they are called "reconciliation courts" instead of "divorce courts" and the idea is taking hold. The avowed primary purpose is that of attempting to rebuild and reconcile rather than of simply severing and destroying the marital relationships.

Need for Special Services

So far as our legal procedure is concerned, I believe this is the most significant achievement in the history of our country in dealing with the social problems we are concerned with. It is plain to be seen, however, that to achieve any degree of success such courts must have available to them adequate facilities to perform these new duties. Judges themselves may just incidentally be, through personal aptitude, interest or experience, capable of properly handling such matters. But the special training and knowledge of judges and lawyers is in another field than the social sciences.



*Family breakdowns
concern her too.*

This does not mean that the lawyer or the judge is unconscious of the human values in the problems before him. He is aware that the resort to excessive drinking, for instance, is not by itself a cause of conduct but is usually the indication of some mental or nervous illness or of maladjustment to the problems of life from which the drinker is seeking to escape. He realizes that this is generally true of the causes stated by the parties and that upon investigation they would often be found to be but superficial manifestations of deeper maladjustments and difficulties.

There are other reasons why the average lawyer or judge is unable to assume the responsibility of ferreting out and dealing with these causes. There is the extreme limitation of time. As to the lawyer, it is almost always against his economic interest to do so. Furthermore, he is primarily interested in the legal rights and duties of his client, with the social aspects of such matters being only of secondary interest.

For these reasons, it is essential to have available trained social workers and the privilege of referral to psychiatrists for the assistance of both lawyers and the court. The court should have the right to use such services and the reports made in connection therewith as a basis for any suggestions or orders it makes with respect to the matters under investigation.

Marriage Counseling

A marriage counseling service, which should be available long before domestic problems reach the stage of resort to the courts, is an even greater need. It would alleviate a great deal of emotional suffering and prove to be a really effective means of striking at this evil of the disintegration of the family. Not only the courts, but lawyers who are genuinely interested in the welfare of their clients, would welcome the opportunity of referring them to the assistance of such a service.

If some members of the legal profession are indifferent to or opposed to marriage counseling services, they perhaps are partly motivated by the belief that the counseling service is an entrenchment upon their prerogatives. Viewed in its proper light, such service would be as valuable to the lawyer as to the judge.

It is inevitable that courts and lawyers must come to realize that the most vital and worthwhile job they do for their fellowmen in connection with marital difficulties is to help to build, unify and maintain the family units. One dangerous idea which must be changed is that lawyers should not be paid unless the divorce is obtained. They should be paid just as certainly and as well or better when reconciliation is made.

It is deemed essential to maintain the services of doctors and hospitals to treat people suffering from physical and mental ailments. Why should there not be some comparable means to treat this family illness which threatens our whole social structure?

It is realized that a job of education and public relations would have to be done before a marriage counseling service could accomplish very much. People are reluctant to resort to such a service. A prime difficulty is that the spouse most at fault is least willing to seek outside help. The very character defect that causes the trouble makes him unable sufficiently to realize his own fault and become willing to accept outside help. For us human beings, it is bad enough to have the faults. We sting with resentment at being told of them by others, and even more so at the implication that they are beyond our own power to cope with. The old adage, "The things people tell us for our own good, seldom do us any" is based on sound psychology.

Then again, there is the consciousness of social stigma and embarrassment attached to resorting to such a service.

It is essential that these attitudes be changed and that the public and the professions be encouraged to use such specialized services. The counseling should be made available so that conferences may be held on a strictly confidential basis in dignified surroundings with properly trained professional personnel.

Marriage Needs Appreciation

The idea of a marriage counseling service is not offered as a panacea for all matrimonial woes. We do not bypass the important thought that if something can be done to change our collective attitude toward marriage and save the institution, it will be done by society itself, primarily through those institutions where proper social attitudes are established: the home, the school, the church and the community. It may seem banal to repeat, but through them there must be a reawakening to the value, the nobility, or if you prefer, the spiritual value of the family unit and the home itself.

Marriage is not a lark. It is fraught with real difficulties. It presents one of the most challenging assignments that human beings undertake. It demands tolerance and understanding and good sportsmanship, including a sense of humor that goes beyond the crass enjoyment of laughing at someone else's discomfiture. It calls for sincere devotion to the highest ideals known to our race, for the old-fashioned virtues — chastity, honesty and unselfish devotion to the purpose of mutual success and enjoyment of the proper objectives of marriage.

These are the values which must be re-established and upon which the solid foundation of society rests. The marriage counseling service can offer some assistance in driving toward that goal.



*Marriage
demands
much
and
gives
much.*



E for Effort

Students Grade a Sex Hygiene Course

At the request of a student body consisting largely of ex-GI's, Springfield College, Springfield, Mass., inaugurated a sex hygiene course in the fall of 1947. The 10-week course was purely experimental and elective. The health education division demanded no prerequisites for the course and gave one semester-hour of credit to those who took it.

Although the class was originally intended for freshmen, many who signed up for it were upperclassmen seriously thinking of marriage or even already married. And since most of them had had to interrupt their education to fight the war, they were about five years older than the usual college students.

The course was in the evening to accommodate students carrying heavy daytime schedules, and their working wives free only in the evenings.

Not Just Any Teacher

The dean told the enrollees they themselves could select their teacher, so they looked around for someone familiar with the material, emotionally stable, able to discuss questions without embarrassment and flexible enough to arrange the course to meet the needs of those who wanted to take it. As a result of their search, they suggested to the dean that Miss Marjorie Young, an assistant professor of health education, teach the class.

The course covered sex hygiene, the biology of reproduction, heredity and eugenics, and the ethics, sociology, psychology and aesthetics of sex.

Mostly, the students and Miss Young discussed these topics, but sometimes Miss Young lectured and occasionally she used visual aids such as charts and movies. The students made free and frequent use of reference materials in the instructor's office next to the classroom.

Those connected with the course had recognized from the beginning that in 10 weeks they could only skim the surface of the subject. As they



*To marry
now or
to wait?*

went along, it became clear also that the class was much too large — enrollment more than doubled in the second semester — for adequate discussion.

To find out exactly how the students thought the course could be improved, Miss Young arranged for them to evaluate it by answering, anonymously, a detailed questionnaire.

A total of 66 men and two women (wives of class members) responded to the questionnaire. Their average age was 22. Twelve were married, 11 engaged, 16 going steady, the remaining 29 seemingly fancy-free.

Of the 56 who reported both parents living, 51 said their parents were living together. In four cases the parents were divorced and in one, separated. In one instance both parents were dead, and in 11 cases only one parent was living. Thirty-one students lived in cities of 10,000 or more, 20 in towns of 2,500 or more, 13 in villages, three on farms and one in a reform school.

Of those whose parents were of different religious faiths, one reported that the children were Protestant, one that the children chose of their own accord the Catholic faith, and four that the children were brought up as Catholics. One student, who specified no religion, said his father had been converted to and the children trained in his mother's religion. Another case involved a Jewish stepfather and a Protestant mother; the boy, who lived mostly with his stepfather, was brought up a Protestant and later made his own choice of religion.

It seemed that the mother's religion was dominant except where the father was a Catholic.

In the children's opinion, difference in religion was no handicap at all to their parents' marriage in five cases, very little handicap in one instance, somewhat of a handicap in two.

Such facts shed light on their attitudes and reactions to the course and illumine their evaluation of it.

How did they feel about whether to marry during college or to wait, a question that perplexes many young people? Thirty-seven said they were in favor of immediate marriage and most of the class looked forward to having three children.

Previous Sex Information

How did they get most of their previous information about sex? Fifty-eight mentioned reading matter, 46 companions, 13 their fathers, and others — with decreasing frequency — their mothers, both parents, doctors, brothers and sisters, college courses in health, clergymen, high school health courses, the Armed Forces, Miss Young's course, movies, relatives and older men.

In answering the question, "Who should handle the money in your family?" they may have reflected the influence of the course when 53 replied both husband and wife, 10 the wife, six the husband.

The students thought the course had great value. Consequently, they said, the college should expand the course and double the credit. Generally speaking, they thought the course needed more time, more content, more credit, more discussion, smaller classes. Eighteen recommended that it be compulsory rather than elective and some thought it should be taught in high school.

Sixty-one students answered that they would recommend the course to freshmen. Twenty-two would recommend the course to married students; one would not.

Some commented that they had acquired more knowledge about marriage and sex and had developed a healthier attitude. Two said the course had cleared up their distorted ideas about sex, and another said it helped to coordinate previous sex information.

*He'd eventually
make a more
understanding father.*





*He was informed
about courtship.*

Some Things They Disliked

Other students commented, less favorably, that there was not enough discussion of sex techniques, that there was not much new information for married students, that there should be a course for married students, that the instructor should be married and that classes should be kept small.

In their comments two students revealed their need for further help. One said, "The course has a rather discouraging effect on those who have already made the mistake." And "It made me wiser when it comes to meeting the problems and hell of married life."

Their responses to "What parts of the course did you dislike?" were frank.

Four said the presentation was too scientific, statistical and cold for an introductory course. Four said that there was not enough class discussion and that questions should be handed in and answered. Three said the lectures were too rapid and skimmed over main points; they noted the lack of a break. Two said the course needed a textbook; they thought there was too much note-taking and dependence on reference materials.

Two felt that too much time was spent on study of reproductive systems and that actual sex problems faced by students were not discussed except generally. Others thought there was not enough illustrative material, not enough scotching of popular misconceptions, not enough time on vocabulary, not enough discussion of male and female psychology, not enough about steady dating, not enough help on postmarital sex adjustment and too much emphasis on abnormal relations.

But 16 appreciated the discussions of the physical side of marriage and of the importance of good sex relations in marriage. Fourteen liked the material on the traits of a good mate, 11 that on marriage preparation and problems, eight that on the honeymoon, seven that on the engagement period. Others commented favorably on the teacher's frankness, and several said they appreciated the discussions of the physiological

functions and psychological aspects of sex, mixed marriages and birth control and the movie on menstruation.

Students said they thought their prospects of marriage were happier since they had had the course, and during the semester the quarrels in one marriage were straightened out. One student regretted that the early part of his marriage had been less happy than it might have been had he known more about the physical side of marriage. Another said he was straightened out about courting, another that he had a new outlook on life. One remarked that he would be a more understanding husband and father.

They agreed that the course was good for morals and encouraged maturity.

They Liked What They Could Use

Apparently these young people liked the course a great deal more than they disliked it. Their reason for approving a specific discussion was usually that they had found it of immediate or potential value.

Here are the subjects they said helped them most: physical side of marriage, choice of mate, physiology of the female, psychology of the female, planning of marriage, birth control, mixed marriage, premarital engagement questions, courtship, sex education in schools, the honeymoon, dating, prenatal development, and how to be a good husband.

More, More, More

The subjects they thought should be expanded when the course was given again were these: physical side of marriage, birth control, how to handle children, petting and courtship, sex education, budgeting, marriage in the later years, security before marriage, wedding customs, choosing a mate, sex problems, delinquency of teen-agers, psychology, boy-girl relationships, family problems, personality conflicts in relation to sex and social interests, premarital morals, and methods of promoting health education.

They recommended that there be required reading, private counseling, case material and guest speakers (specifically, married doctors, nurses and fellow students).

*They prize an
attractive
personality.*



Would You Marry?

Most of the 68 students answered all the final revealing questions in the questionnaire: "All other factors being satisfactory, would you marry . . .?"

A person of lower economic rank than your own?	64 yes	4 no
A person decidedly not good-looking?	30 yes	37 no
A person of unattractive disposition and personality?		68 no
A person of lower moral standards than your own?	4 yes	62 no
A person from a family inferior to your own?	46 yes	20 no
A person of different religious faith than your own?	37 yes	24 no
A person who had had premarital sex relations?	41 yes	22 no
A person who had been divorced?	32 yes	33 no
A person who would not have children?	8 yes	58 no
A person of much less intelligence and education than your own?	10 yes	56 no
Do you want your mate to be older than yourself, the same age, or younger?	48 younger	28 same 5 older

How much older or younger? About 3 years younger was average.

Those who plan college marriage education courses will find sound guidance — on what to do and what not to do — in the comments of the Springfield students. Mostly ex-GI's and therefore older and more experienced than the usual college students, the young men and women of the Springfield experiment, along with their college and instructor, merit an E for Effort in the building and strengthening of their course.

CREDITS

Joseph A. Stone, p. 115.

NEA Staff Photograph, p. 122.

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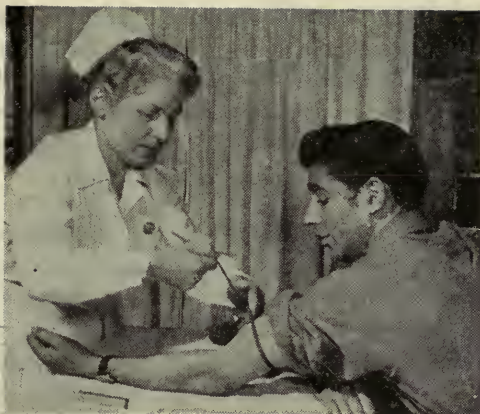
USPHS, VD Division, p. 131.

An Arthur Leipzig Photograph, p. 133, p. 136.

Army Times, January 19, 1952. Cartoon by Townsend, p. 137.

CORRECTION

The picture on p. 51 of the February Journal of Social Hygiene was used with the gracious permission of the Cleveland Health Museum and should have been so credited.



by ann f. matthews

the vd patient . . . an individual to the hospital nurse

To the professional nurse who understands the various factors which make every patient an individual, the venereally infected person presents a distinct challenge to her skill in administering total nursing care. From the former limited concept of nursing as the skillful performance of techniques and clinical procedures, nursing is now looked upon as an art and a science in which each patient is recognized as an individual whose emotional and physical components must be considered as inseparable if comprehensive nursing service is to be rendered.

A Responsibility for Every Nurse

The professional nurse, wherever she functions — in the hospital, outpatient department, school or industry, on private duty or in public health work — will at some time, directly or indirectly, have to meet her responsibilities toward the venereally infected person. She must be prepared to accept these responsibilities and be capable of giving what assistance she can in guiding the patient so that he can obtain the help he needs.

The preparation of the nurse to meet successfully the needs of the patient should be initiated while she is a student. At this time scientific knowledge relating to the causative agents, mode of transmission, general manifestations and treatment is coupled with her education in the socio-economic factors which make the prevention and control of venereal diseases a social as well as a medical problem.

To give nursing care to the venereally infected man, woman or child, it is necessary for the nurse to adapt to each individual her understanding of human behavior and to employ the scientific knowledge she has acquired in order to recognize the needs of the patient and to help him in the solution of the physical, emotional and social problems which may result from a diagnosis of syphilis or gonorrhea.

To deal successfully with the patient, the nurse must have clarified her own feelings toward the venereal diseases and have developed a philosophy of life and health. She must possess a wholesome attitude regarding sexual activity and an appreciation of the social and economic conditions which influence the lives of all. With this self-evaluation, she is better able to understand in others the factors which may be considered as the underlying cause of the spread of venereal diseases.

Factors Affecting VD Prevalence

That low socio-economic conditions have a direct relationship to a high prevalence rate of syphilis was brought out in a study in Georgia¹ in which data concerning home ownership, monthly rental, racial composition of the population, water facilities, possession of telephone, and number of years of school completed were collected during a mass blood-testing program.

Because a low level of educational attainment and mental ability appeared to be a common characteristic among 500 venereally diseased women studied at the Mid-Western Medical Center,² it may be assumed that the possibility of acquiring syphilis is greater among these people than those of high intelligence or better educational advantages.

It may further be assumed that the venereal disease rate will be in direct proportion to the degree of sexual promiscuity in any given area. The underlying cause for a high degree of sexual promiscuity can usually be credited to economic conditions, personality problems or the cultural pattern of the locality.

With the acceptance of these assumptions, the nurse must expect to find a greater number of venereally infected persons among these groups, but at the same time she cannot accept as a tenet that persons of high intelligence or good educational and social background are immune.

¹ Bowdoin, C. C., Henderson, C. A., Davis, W. T., Jr., Morse, J. W., Remein, Q. R., *Socio-Economic Factors in Syphilis Prevalence*. Journal of Venereal Disease Information, vol. 30, no. 5, pp. 131-139, May 1949.

² Wertz and Rachlen: *Mental Ability and Educational Allotment of 500 Venereally Infected Females*. Journal of Social Hygiene, vol. 31, no. 5, pp. 300-302, May 1945.

The student nurse
gets acquainted
with the needs
of the VD patient.



Routine Blood Test

Fortunately, today most hospitals require a blood test for syphilis of all patients at the time of admission. These tests have revealed many unsuspected cases of syphilis in persons from all levels of society.

The routine serology test must be thought of as merely a screening device. Positive serology is not absolute proof of a syphilitic infection nor does a negative blood test exclude the presence of the disease. It is particularly important for the nurse to remember that a person admitted to the hospital for a complaint other than venereal disease may very possibly produce a temporarily false positive reaction due to other infections or other antigens. A single positive blood report is not sufficient basis for assuming that the patient is infected.

It is likewise important to remember that persons in the incubation or primary stages of syphilis will have a negative blood test but may have other clinical manifestations which should be recognized and reported to the attending physician as soon as they are noted.

When a previously unsuspected case of venereal disease is found in a hospitalized patient, it is necessary—in order that the patient obtain maximum benefit from his hospitalization—that the nurse be ready and able to work with the doctor in planning the patient's care, including chemotherapy, antibiotics and the reduction to a minimum of the psychological trauma and tensions potentially inherent in such a diagnosis.

It is unquestionably the responsibility of the physician to inform the patient that syphilitic infection is suspected and to explain to him the need for treatment and the importance of bringing to treatment his sex partners.

More Than Skill

A very important part of the nurse's work is to give the patient an understanding of a positive approach to health. Things that are learned in an emotional situation stay with the individual, and the patient will retain what he learns from the nurse who teaches about the disease at the

time she is caring for his physical needs. The nurse whose service to the patient ends with the skillful performance of technical procedures will find her job incomplete. The intangibles of nursing — constructive conversation, encouragement and kindness — are important to the patient and are essential to the nurse who wants to give successful nursing care and to find satisfaction in her work.

For the teaching to be of value to the patient it is necessary that the nurse evaluate the individual with an appreciation of his socio-economic background, his mental ability and educational advantages, together with a consideration of the emotional tensions and fears which may be evident or concealed in accordance with the personality of the patient.

Because of the hours she spends in close association with the patient the nurse is able to recognize emotional disturbances in an early stage and to gear her approach in such a manner as to gain his confidence and to gauge his lack of knowledge and his fears concerning the venereal diseases.

Fear

The word *syphilis* is fairly familiar to a large portion of the population. A few have a sound or intelligent understanding of the disease, but there are many others whose scanty knowledge, false ideas and beliefs have developed as a result of conversations with and advice from well-meaning but poorly informed friends. Badly presented facts or stories of crippling, blindness and insanity are instantly recalled by the person who receives a diagnosis of syphilis. The belief that these are the inevitable results of the infection and are to be his ultimate fate arouses in the misinformed patient visions of complete ruin of his life and his family.



Most hospitals require
a blood test for syphilis.

ANN F. MATTHEWS

*Hospital administrator
and supervisor.
Formerly with DP
program in Germany.
Now Nurse Officer,
USPHS Hospital,
Boston, Mass.*



Fears of crippling, social ostracism, job loss or family upheaval are sufficient cause to prevent any person from seeking assistance or accepting a diagnosis of syphilis. The hospitalized patient who has already faced the financial and psychological problems inherent in hospitalization may easily develop an attitude of despondency, rejection of assistance, or apathy in the face of this added problem.

In displaying a friendly, noncritical and confident attitude, the nurse is able to assure the patient of her interest in him as a person. By intelligent teaching—adjusted to the individual patient—she provides him with an understanding of the disease which is stimulating, interesting and valuable to him.

When he understands the disease and accepts the responsibilities to others which he incurs as a result of the infection, the patient will usually seek further assistance from the nurse. He may ask for help with personal problems related to his home, his job or his position in the community. Even though a sound understanding of the disease will alleviate many of the patient's fears relating to his physical health, the personality problems reflected in a case of acquired syphilis must be recognized if total nursing care is to be given. The conflicts which arise as a result of maladjustments in the economic, social, religious or sexual spheres of the patient's life may frequently be solved with a little assistance from the nurse.

A Member of a Team

She may not be able to handle all the problems her patient presents, but she is equipped to give assurance, constructive sympathy and wise advice. Realizing her limitations in dealing with all problems which may arise, she makes use of the community agencies equipped to give the assistance needed. In working as a member of a team, she refers problems which are out of her immediate sphere to the doctor, the hospital chaplain and the social worker, and through the community nursing service to other agencies as indicated in accordance with the established policies of the hospital in which she is employed.

An illustration of the hospital nurse's opportunity to practice the principles of social and health nursing can be demonstrated by the case of Lucy G., aged 13, who was admitted to the hospital at one o'clock one morning following an automobile accident. While giving the girl bedside care, a nurse noted a lesion on the external genitalia. Darkfield examinations were positive and a diagnosis of primary syphilis was made.

The Mother Worked Nights

Discussion of Lucy's condition with her mother revealed that because of separation of husband and wife, Mrs. G. had been forced to work outside the home to support her family. Employed at night, she had been able to exercise little supervision of the girl's social life during the hours she was not in school. The mother knew Lucy went out with boys, but "so did all the girls her age." Mrs. G. admitted that she had avoided all conversation relating to sex with her daughters because she felt them "too young to know such things."

The nurse realized that Lucy's infection, as with most cases of acquired syphilis among this group, resulted from neglected sex education, a misguided sense of real values and an unhappy home environment. In her conversation with Mrs. G., the nurse gave her some assistance regarding the teaching of sex behavior and explained why she should start now to give Lucy and the 10-year-old daughter, Marjorie, some instruction regarding normal sex activities and to teach them healthy sex habits. Arrangements were made for Mrs. G. to see the hospital social worker, who through a community agency was able to place Mrs. G. in employment which permitted her to be home in the evenings.

With the mother's approval, the nurse gave Lucy a simple explanation of what syphilis is and why it would be important for the boys she "had been with" to be examined. Because of adequate handling of this case by the hospital nurse, the public health nurse's job of following through on epidemiological procedures required in communicable disease control was greatly facilitated.



Technical proficiency
plus
a feeling for humanity.

Application of scientific knowledge on the part of the nurse led to the discovery of this case and four additional cases of primary syphilis in teen-age boys and girls. Adaptation of her understanding of behavior led to her success in building good relations with the family and consequently enabled her to fulfill her obligations in giving total nursing care.

The Broad Viewpoint

To recognize the dignity of a patient, to consider him as an individual, to assist him in his restoration to health and to instruct him in the preservation of personal and community health are the principles of nursing.

Because of all the factors to be considered in the spread of venereal diseases and because control of these diseases is dependent upon the response of the patient to the assistance offered, the professional nurse, by applying these principles of nursing, makes a valuable contribution to the control, prevention and eventual eradication of the venereal diseases.



"Isn't it swell we can go to the PX for refreshments where we're not bothered by dames?"

BOOK NOTES

Handbook of Diagnosis and Treatment of Venereal Diseases, by A. E. W. McLachlan. Baltimore, Williams and Wilkins Company, 1951. 4th ed. 368p. Ill. \$4.50.

Because this book is succinct, small, well illustrated and yet comprehends all five venereal diseases, it should be welcomed with gratitude by medical students, always under high pressure to learn too much in too little time. The author well represents the relative conservatism of British physicians—in still giving honorable places to the iodides, mercury and tryparsamide in syphilis therapy, while American authorities generally have relegated these drugs to history.

CHARLES WALTER CLARKE, M.D.
*Executive Director
American Social Hygiene
Association*

◆ ◆

Unraveling Juvenile Delinquency, by Sheldon and Eleanor Glueck. New York, The Commonwealth Fund, 1950. 339p. \$5.00.

Most recent of Commonwealth Fund studies on crime and delinquency, this report covers a 10-year study of 1,000 boys from similar ethnic and religious backgrounds, one-half of whom were delinquent.

On three major points the two groups of boys were extremely divergent. If the father's discipline was

not steady and humane, if the parents were not interested in the boy and sympathetic toward him, if the home was not a place of affection and co-operation—then there was a good chance of the boy's becoming delinquent.

The second major point involved the boy's ability to get along with others. Excessive assertiveness, defiance, impulsiveness indicated delinquent inclinations.

The third point concerned personality traits. Those children who pursued their own devices, were emotionally unstable, liked excitement or were easily swayed by appeals to their emotions were found to be delinquency-prone.

Another interesting point of difference in the two groups was that the muscular types of children tended to find themselves in the courts far more frequently than the less sturdy types.

It is the home-life factor which can be most easily remedied, and the Gluecks have done a service in emphasizing the importance and relative economy of improving the quality of the home before delinquency occurs.

◆ ◆

Psychosomatic Gynecology, by William S. Kroger, M.D., and S. Charles Freed, M.D. Philadelphia, W. B. Saunders Company, 1951. 503p. \$8.00.

Of interest to physicians as a reference text stressing the relationship between the physical and emotional processes that effect the female reproductive organs, this book insists

on the integration of gynecology and psychiatry.

The authors discuss the psychosomatic aspects of the fetus, the infant and the pregnant woman, common psychosomatic problems and methods of diagnosis and treatment.

Equipped with a glossary of technical terms and an index, the volume is written in a style that will present no difficulties to the physician not especially trained in psychiatry.



Health in Schools. Twentieth Yearbook. Washington, D. C., American Association of School Administrators, 1951. Rev. 477p. \$4.00.

Of value to all school health administrators, this revision—containing new material on mental hygiene and noncommunicable diseases and defects—shows how schools can cooperate with other community agencies to promote health.

Although the emphasis is on administrative problems, the individual child is not forgotten.

It is pointed out that transmission of VD rarely occurs within the precincts of the school itself. General health precautions are recommended, however, such as the exclusion of children with skin rashes or mouth and throat inflammations, unless the cause is determined.

Emotional maladjustments must be corrected if the pupil, however clever scholastically, is to avoid later unhealthy attitudes and marital unhappiness.

How to Retire and Like It, by Raymond P. Kaighn. New York, Association Press, 1942, 1951. Revised. 149p. \$2.50.

For the individual who is alive and growing, interested in hobbies, retirement need not be accompanied by a sense of being out of things. Nor will he have difficulty in getting along with his wife, his friends and the younger generation.

Common sense, the light touch and actual quotations from "retirés"—all these make an easy-to-read book for those who have retired and those who would like to prepare for retirement.

"To Remarry or Not?" is a chapter newly added. It finds that "presumably the sense of loneliness is the strongest urge for remarriage." Reasons for and against second marriage are noted with the conclusion that some of the same risks are involved in the second venture as in the first.



The Family Scrapbook, by Ernest G. Osborne. New York, Association Press, 1951. 457p. \$3.95.

The scrapbook idea has been carried out by brief subject discussions of only one page in length, including humorous top-of-the-page miniature illustrations. The first impression is that of interesting trivia, because in order to keep to the form so much has been left unsaid. Nevertheless, the total effect of these brief discussions, one after another, is a profound feeling that there are satisfactions in family living that can be

gained comfortably if one's children are accepted as experimenters with life and relationships.

Confusions in the attitudes of parents when facing "problems" with their children are clarified in simple, homey language and with a nice sense of the serious desire to be good parents that underlies these confusions. Usual problems from infancy through childhood are included. Many problems arising out of children's relations with their parents are discussed with sympathy for both adults and children.

Interpretations of the ways in which a child learns are excellently presented not only in specific discussions on learning but in general discussions. They all are noted in the topical guide.

At times Dr. Osborne draws upon his own family experiences as a father to illustrate a point—consistent with the expressed purpose of the book as a "sharing" with other parents. His emphasis on the father's—as well as the mother's—relationship to the child and the family is particularly helpful.

From the standpoint of the professional person working with parents and children, one could wish for a more adequate term whenever an expression relating to theoretical material is introduced, such as "period of latency." The constricted sense in which this phrase was used might easily give laymen a somewhat false impression regarding what is really known about children of this age. There is considerable professional literature regarding these years and their special significance in the development of personality integrity,

although it is true that there is a paucity of material available to the laity.

Lack of technical language in general makes this book valuable as an orientation for the prospective parent who wants to learn about children and family living. Any parent would enjoy and profit from Dr. Osborne's sensitivity to childhood. The brevity of these discussions has special value in not confusing the young parent, and there are several references to pamphlets for further reading.

One of the special features of this book is information on ways to have fun as part of a family, including suggestions for simple materials that can be utilized.

LORETTA MOONEY

*Senior Psychiatric Social
Worker*

*Northern N. J. Mental Hygiene
Clinics*



Marriage, Morals and Medical Ethics,
by Frederick L. Good, M.D., and
Rev. Otis F. Kelly, M.D. New
York, P. J. Kenedy & Sons, 1951.
202p. \$3.50.

Written in popular style, this book is addressed to priests, physicians, nurses, social workers and all who need information about the Catholic position on medico-moral problems.

Stressing basic principles of morality, it considers marriage as a natural contract and sacrament, clarifies canon law concerning marriage, points up the moral responsibilities of physicians and discusses the medical aspects of ecclesiastical matrimonial court procedure.

The section on sexual constitution discusses the reproductive organs,

adolescence, sex education and the climacteric. There is detailed material about pregnancy with emphasis on the duty of the physician to save life.

The rhythm method for regulating conception is explained and is found not to be contrary to moral principles under certain conditions, whereas mechanical procedures are condemned. A section on psychiatry interprets this branch of medical science in terms of Catholic thought.

There is much here that will enlighten priests and physicians and that will answer questions of Catholics and non-Catholics alike.

◆ ◆

Understanding Your Son's Adolescence, by J. Roswell Gallagher, M.D. Boston, Little, Brown and Company, 1951. 212p. \$3.00.

This book reminds parents that diversity among adolescent boys is a normal thing. An understanding of the reasons for their behavior is imperative if the boys are to be helped and the parents reassured.

Products of their heredity and environment, boys have basic needs they must fulfill, and they must adjust and grow — all without the long-time experience of their elders. What seems like defiance may only be a fumbling attempt at self-assertion.

"Get in at ten tonight — and I don't want any discussion about it" and "Say, Ken, what's the real story behind these late hours?" are two ways of approaching the same problem. There's no doubt which one

Dr. Gallagher considers the better lesson in human relationships.

There is much sensible advice on health matters and liberal use of quotations which will seem painfully familiar to many parents. Chapters on sex, school failure, mental health and misbehavior emphasize again the need for understanding reasons, both on the part of boys and their parents, for exercising justice acceptable to the boys, and for holding tight to a sense of humor.

◆ ◆

The Retarded Child, by Herta Loewy. New York, Philosophical Library, 1951. 160p. \$3.75.

"It is just as possible to evolve out of half, and often much less than half, of a child a whole and worthwhile adult." This is the lodestar of Hilda Loewy's philosophy.

The author cautions against playing with dolls by very young retarded children, since this activity can become obsessional because the sex instinct is unprotected. Early play should be manipulative.

Parents must face the fact of mental retardation and plan their child's training accordingly.

◆ ◆

The Battle for Mental Health, by James Clark Moloney, M.D. New York, Philosophical Library, 1952. 105p. \$3.50.

This book is a plea for building confidence in infants and children

from birth through the early years by means of relaxed, natural attentions of "motherly" mothers.

Permissive child-rearing methods practiced by primitive tribes are contrasted with those of advanced civilizations, to the disadvantage of the latter.



A Citizens' Handbook of Sexual Abnormalities, by Samuel W. Hartwell, M.D. Michigan, Report to the Committee on Education of the Governor's Study Commission on the Deviated Criminal Sex Offender, 1950. 70p.

This 70-page treatise was prepared to fill the need for more basic information among those without either an experiential or educational background of sexual deviation and psychosexual development.

The four chapters are divided into two parts. The first section, written by Dr. Hartwell, describes common types of sexual deviations and comments on their relative seriousness from both the individual and societal point of view, discusses common fallacies about sex deviates and mistakes society is making in dealing with them, and describes the mental hygiene of sex and the stages of psychosexual development.

Donald M. Thurber, the Commission's executive director, wrote the last part on coming to grips with the problem, which points out the difficulties encountered by the Commission (and by any agency dealing with this problem) in formulating valid, poignant recommendations in

many areas of education, fact-finding, legislation, and moral and spiritual values.

As a means of presenting one aspect of the human personality if synthesized with an understanding of other areas of development such as social, emotional and spiritual, the psychoanalytic section of the handbook would lead to a better understanding of deviate sex behavior, since it presents in a simple, clear manner the stages of psychosexual growth.

The last section with its broader frame of reference should prove most enlightening to the panacea-seeker. While only cursory mention is made of the multitude of suggested solutions (both of a non-professional as well as conflicting professional nature), this part should impel the non-Freudian-oriented to re-study the first part of the handbook and to ponder the many ramifications of any solution and the pitfalls of the ready-made ones. There is no catholicon for the problem of the deviated criminal sex offender.

DONALD H. GOFF

*Assistant Director of Classification
and Education
N. J. Department of Institutions
and Agencies*



Contemporary Correction, by Paul W. Tappan. New York, McGraw-Hill Book Company, 1951. 434p. \$5.50.

If one were searching for a source from which to gain broad insight into the policy of correction in the United States and understanding of the philosophy of those who formulate the

policy and objectives and administer the procedures and techniques, Dr. Tappan has made available such a book in *Contemporary Correction*.

Arranged in five sections, the book is composed of a series of separate articles or reports prepared by 32 leaders in the penal and correctional field. With a foreword by Sanford Bates, interpretative commentary by Dr. Tappan and concluding chapter by Austin H. MacCormick, *Contemporary Correction* covers every phase of the correctional program.

To explain his method of telling the correctional story, Dr. Tappan states: "Unhappily, most of the traditional literature on penology, particularly the more extended works, has dealt chiefly with history, and with policy as conceived by a single individual—and this gives a quite misleading impression of the field. . . . correction has suffered from the lack of a comprehensive, integrated, and, at the same time, authoritative

collection of materials on the functioning whole. It is our hope that this volume, with its emphasis upon the contemporary scene and upon the collaboration of professionalized skills, may fill the gap." To a most satisfying degree, Dr. Tappan achieves his purposes in welding together into one publication the major aspects of contemporary correction.

One need not agree with all of the views expressed by the separate writers nor regret that the policy of probation has not received more extended treatment to recognize that this book has filled a long-felt need. For judges, correctional workers, social caseworkers as well as for members of the lay public interested in finding answers to many problems which disturb both administrator and citizen, it is a valuable source of reference.

JOSEPH P. MURPHY

*Chief Probation Officer
Essex County (N. J.) Probation
Service*

Social Hygiene Day Slogan

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Fight VD and Vice

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Journal of SOCIAL HYGIENE

vol. 38

april 1952

no. 4

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About our cover . . .

The Visit to the Nursery, by Jean Honoré Fragonard.
Thirteenth of a series of Journal covers on family
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of Art, Kress Collection, Washington, D. C.

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THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association. Subscription price: \$3.00 per year. Single copy: 35¢.



• family life education – extension style

by mary w. armstrong

"Better Homes for Better Citizens" might well be the slogan of the home economics extension service of Rutgers University. All the projects promoted by the home economics extension staff are directed toward this end, but most especially the human relations program.

And this program, just as the name implies, is aimed at developing better relationships among family members of all ages, with each other and with those whom they meet at school, at work or at play.

But in line with theories of long standing, recently given added emphasis, that the early formative years are the significant ones, child development and parent education are the keystone of the study promoted by extension workers.

volunteer lay leaders trained effectively

The 10,000 or more parents who, during the year just ended, were enrolled in New Jersey extension groups were predominately concerned with problems of school-age children. This is partly due to a fortunate cooperative relationship developed more than 20 years ago with the New Jersey Congress of Parents and Teachers.

In several counties in the state—among them, Bergen, Camden, Essex and Union—a series of training meetings for local study group chairmen has been carried on each year during all that time. Techniques of presenting material—including films, skits, panel discussions and reports on reference reading—have been illustrated, as well as subject matter explored. Through the work of these volunteer leaders the number

of families influenced by extension programs has nearly doubled, and the effect on the leaders themselves has also been noteworthy.

Mrs. G in Union County, with only a common school background, has attended classes over a period of 10 years. During that time she has grown not only in her understanding of her children but also "in wisdom and stature." Her children have graduated from elementary to secondary school and have gone to work or entered college; she herself has "graduated" from a shy, self-conscious mother, first to a back-row group member, then to a community association officer and finally to a valued worker at the county level, able to express herself well, to report on meetings and convincingly persuade other mothers of the value and satisfaction of "parent ed." This is the affectionate colloquialism bestowed upon the program by many enthusiastic adherents.

wide range of subjects studied

The state specialist in human relations has each year outlined appropriate subjects for study at county and community meetings. In some instances she has conducted most of the county-wide training meetings; in others she has assisted the home agents—usually county field workers, although they are members of the faculty of the College of Agriculture of Rutgers University, as is the specialist—to do the job by recommending reference materials and teaching devices, as well as by preparing bulletins for general distribution.

Although the choice of specific study topics has varied from county to county, a review of some of the different programs in Union County suggests the type of information which parents and others seem to appreciate.

Among the subjects presented to volunteer leaders during the year just past, "What Are These Emotional Problems?" received the most enthusiastic response. Within six weeks after the writer conducted a meeting using the excellent film by this title as the basis for discussion, 12 parent-teacher groups had held similar meetings, in most cases without further help from the extension staff member, except perhaps a few admonitions and a little bolstering of courage.

"Discipline for Self-Discipline," "Responsibility Scaled to Size," "A Goal for Living" and "Helping Your Child Make Good in School" are also typical of the program themes offered to county and community groups.

The training meeting topics have included also "You and the United Nations," "Planning for Family Security" and "Business Facts for New Jersey Homemakers," since the extension service feels very strongly that practical economics and international conditions have definite bearing on family living.

*how can you
help your child
in school?*



many organizations request programs

The home agent has promoted better family living with many other organizations through requested programs such as "Developing Our Best Selves." This title—originally announced to add appeal to a training meeting in leadership techniques in the parent education field—quickly caught on with other groups as a result of press notices. Subsequently presented to a Democratic women's organization, two women's club home departments and a Business and Professional Women's Club, the angle of personality development as an aid to individual happiness as well as to community participation was stressed.

"Loosening the Apron Strings," presented to mothers of adolescents, "Preparing for Marriage," discussed with a mixed group of newly marrieds and mothers of about-to-be-marrieds, and "Economic Aspects of Marriage," given at one meeting in a series for young adults arranged by a county health association—all these show the further scope of the miscellaneous work in this field.

"Education for Family Living," a discussion enthusiastically received by one Kiwanis and one Rotary Club, indicates other avenues of approach provided through cooperation with the Union County Youth Welfare Council, on whose executive committee the extension agent serves.

As chairman of the parents' programs committee for this group the extension agent has for several years not only cooperated with the annual conference programs, attended by from 400 to 600 young people and adults, but has also arranged numerous other conferences in which five or more community agencies interested in youth and family living have participated.



*help her untie
the apron strings.*

More and more church groups formed to study family and child problems have turned to the extension agent for subject presentations and counsel. The child guidance group of a Presbyterian Church in one town is typical of many such groups. "Eating Problems of the Young Child" and "Training in Responsibility" have been two favorite topics with these.

pre-school course launched

Study by mothers of pre-school children, although long recognized as one very logical road to the destination of more satisfactory family living, until recently was far too infrequently used. The occasional short and disconnected journeys along this pathway were usually beset with small attendance—to say nothing of the hazard of rightly restive children and naturally disturbed mothers. During the year just past, however, initial progress was made, providing at the same time courage and experience for future undertakings.

Feeling that any program, to be effective, must be given considerable importance in the eyes of the mothers and others interested, the home agent—with the support and encouragement of the human relations specialist—announced a series of six meetings as a course on child development. Twenty or more mothers of older children who had previously worked with the extension service immediately registered. Since these mothers had other means of obtaining information, the home agent resolutely risked no enrollment at all by discouraging this group in order to seek out mothers of young children.

Even after considerable plugging, the course started with only 18 mothers, although 25 seemed a desirable number. A poll of the mothers themselves showed the morning period from 10:00 to 11:30, when no naptime conflicted, to be the choice for classes. Meetings were scheduled on Wednesday of each week.

A temporary day nursery had been promised, if necessary. All question as to need was settled at the initial meeting when five children—ranging in age from eight weeks to five years—arrived with their mothers.

Arrangements were made for the mothers to meet in the demonstration room on the first floor of an annex and for the children to play in the conference room of a seventh-floor court house office. A variety of play materials was made available and a competent woman known to understand children was engaged. Each mother paid 25¢ for the hour and a half period for each child.

At one session when neither of two “dependables” on the list was available, members of the clerical staff pinch-hit. Two were mothers of older children and another, newly married, was fascinated by the baby.

The children themselves enjoyed their sessions thoroughly and one four-year-old asked his mother each morning, “Do you and I go to school today?”

Before the completion of the course 26 different mothers were enrolled. Although fewer than half were awarded certificates for satisfactory participation and perfect attendance, interest and enthusiasm were general. Illness of children and husbands—and of the mothers themselves—interfered with attendance.

At the last session, the mother of a 14-week-old baby was three minutes late. Upon her arrival, the complete consternation which had prevailed was instantly transformed to total jubilation that something had not happened to spoil her perfect attendance record and prevent her from “graduating.” This mother wheeled the baby in its carriage onto the elevator each week, and all the elevator men and janitors in the staid court house took an interest.

*fun for tots
while
mothers learn.*



In fact cooperation was general in every respect. The sheriff's office provided film equipment and an operator for showing the movie, "Children's Emotions," at one meeting. And later the identification bureau photographed the groups of mothers and children.

Besides the county extension agents and state specialist, speakers included the director of guidance in the Irvington schools and the director of the Egenolf Day Nursery, in Elizabeth. A Plainfield child-care center, sent a representative to every session possible and the county pre-school chairman for the Parent-Teacher Associations also attended.

Many of the "graduates" are reserving a place for friends or relatives on the roster of the next course in Elizabeth, to be given next fall, and some parents in Plainfield have requested a similar program at that end of the county, perhaps in the spring of 1952.

The subjects discussed were: "Understanding Our Children," "Foundations of Good Nutrition," "Daily Activity and Recreation," "Growth in Responsibility," "The Why, What and How of Discipline" and "Solving Those Emotional Problems."

program is state-wide

Although this account of subject matter and techniques in the family living program of the New Jersey extension service has been related largely to activities in a single county, similar opportunities are to some extent provided to parents and others in most of New Jersey's 21 counties. The state specialist's weekly column for parents—entitled "Family Life Today"—is published in daily and weekly newspapers all over New Jersey. In one county alone, the circulation is more than 200,000.

From a national standpoint, too, extension groups from Maine to Florida and California are learning about family living.

Other organizations, in recognition of the success of the family approach in extension teaching, are calling upon various representatives to assist with programs. The recent request of the American Home Economics Association—that Mrs. Lydia Ann Lynde, extension specialist in parent education in the federal government, serve as a consultant in setting

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Home agent in Union County, N. J.
Mary W. Armstrong.*



*the baby's mother
had a perfect
attendance record.*



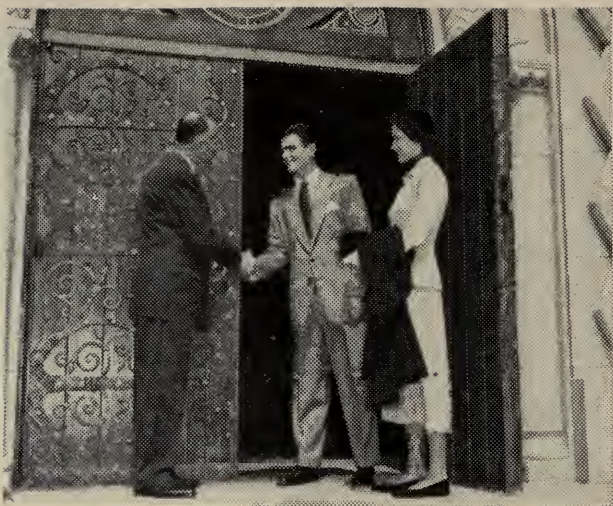
up a special project in family life education, in order to promote a family-centered point of view in all home economics teaching—is one illustration.

family life education is worthwhile

Family life education is one of five major home economics project programs in the extension service curriculum. To some of the staff it is the most stimulating and rewarding of all activities. Although it is the most intangible of all fields of endeavor and the most difficult one in which to measure successes, it is the one wherein the greatest impact is made on future society.

The acute interest and appreciation of participants is at the same time challenging and rewarding.

And to those who have worked in this field for one or two decades and have witnessed not only the seed sown but the harvest reaped, there is infinite satisfaction. For it has been truly said, "The hand that rocks the cradle, rules the world." And who among us does not want to help the next generation build a better world for all mankind?



THE CHURCH, THE FAMILY, THE MINISTER

A Yale Divinity School Course

by Rev. Dr. Paul Herman Vieth

For 20 years the Divinity School of Yale University has offered a course on the church and the family. This course was initiated in recognition of the important place of the family unit in the fellowship of the church and of family situations and problems in the work of the minister.

In the intervening years, the place of the family in Christian education has received increasing attention, and service to families generally has become more and more important in the ministry. It is no longer possible to consider any man or woman properly trained for service in the church who has not had proper preparation for ministry to families.

I. Purposes

The primary purpose of such a course is professional, that is, to prepare ministers for a more effective ministry. It is with this purpose that we shall deal in this article.

There is, nevertheless, an important secondary purpose which grows out of the fact that most Protestant ministers marry and have families of their own. Personal preparation for Christian marriage and family living is as necessary for the prospective minister as it is for those to whom he is to minister.

This secondary purpose is best achieved as a by-product of the course aimed at professional preparation. It would be difficult to deal with it directly. Theological students are in varying status with respect to marriage. Some are married and have children, some are recently married, some are engaged, some are "unattached" and some plan never to marry. It would be difficult to find common ground for any class.

But the content of a professional course aimed at preparation for ministry to families does at many points touch the personal needs of participants (including the instructor!), and each may appropriate to his own use whatever fits. A study of the voluntary reading engaged in by students in such a course indicates that this is the way it does work out. Through the years the quantity of reading done in this course has far exceeded that in any other course the writer has taught.

For the prospective Protestant minister—even more than for persons generally—this personal preparation for marriage and family living is important. Just as wholesome moral and spiritual character are essential to his guidance of others in religious living, so a healthy Christian family life in the manse is essential to effective guidance of others in achieving a similar goal. The minister's own family is his best resource in teaching others, especially the young people of the parish.

II. A Minister Serves

The purpose and content of a course on marriage and the family are determined by the kind of service it is expected that the minister will be called on to perform. This varies in different types of parishes, but in general may be expected to include the following activities:

- Performing marriages.

This may be simply a perfunctory fulfilling of the letter of the law or it may be an opportunity for fostering a high spiritual experience. To be a Christian experience, a wedding needs to be more than the reading of the wedding service and the hearing of the marriage vows. Increasingly ministers are insisting that those who come to them for marriage shall give them also the opportunity for enough time in counseling to make certain that the significance of Christian marriage is understood. Many ministers are regarding this as one of their most strategic educational opportunities.

- The Christian education of youth, including the meaning of Christian marriage and family life.

Proper preparation for marriage is begun long before the few periods of intensive counseling in connection with a wedding. It is incidental to the whole range of Christian education and should become explicit in work with high school and older young people.

There are few churches now which do not include occasional units on love, courtship and marriage in the program of youth work. The tragedy is that so often this is superficially and poorly done. The minister is usually the best person to conduct such a course, and often he is the only one available who can do so.

The Home Is Basic

- Maintaining the proper relationship between Christian education in the church and Christian nurture in the families.

It is now generally recognized that in-church educational activities alone cannot provide adequate Christian education. What the home is and does is more important to what its members become than what is taught in the few hours available in the church.

But what the home is and does is the church in action just as much as the Sunday school and the youth group, for it is through helping homes to be cells of Christian nurture that the church is performing one of its most important services. Basic to any effective Christian teaching is a wholesome Christian family life which illustrates and supports it.

In recent years there has been an attempt to make Christian education a joint responsibility of church and home. Church school curricula now provide for home activities as well as church programs.



A Living Reality

But merely providing for this in printed literature is not enough. It must be made a living reality in the parish. Only the minister, with his intimate contacts with families, can bring this to pass.

- Conducting classes and conferences with parents.

Education for Christian family life is a continuing process. It is only after they are actually confronted with family situations that persons can best be helped to meet such situations.

Adult education in the church has taken on new significance and vitality as it has included groups of parents who are concerned with learning how to make their homes centers of Christian living.

It's more than vows.



- Counseling on marriage and family problems.

Work with individuals and small groups has come to be recognized as one of the most important functions of the minister. It is through such intimate contacts that much help can be given on matters of family relations and problems.

Counseling opportunities do not always grow out of crises. A large proportion of this kind of service may be in the nature of helping persons to do better what they are already trying to do or to discover new opportunities and responsibilities. Thus help may be given with the prayer life of the family, wholesome reading material, support of worthy causes, wholesome family activities, and problems of discipline.

The Parish Call

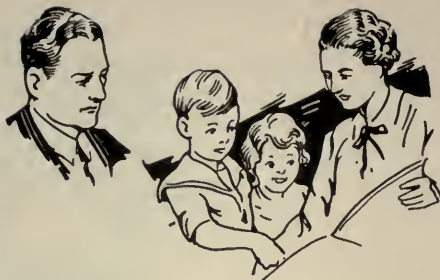
The traditional parish call may take on new significance through the opportunities suggested here.

At times, however, there are crisis situations in the relations of husband and wife or of parents with their children which give rise to the need for counseling. In these the minister must be able to help them think through their problems, with relevance to their Christian convictions.

In acute problems he needs to help in enlisting more expert service than he is able to render.

- Maintaining community relations.

A church is a part of the community and so are the families which it seeks to serve. Wholesome family living is importantly related. The effective minister must know how the community is influencing the values



Children learn
concern for others
within the family.

he is seeking to maintain. He must know the family-serving agencies and have such contacts with them as will enable him to utilize their services.

Moreover, the minister is in the nature of his calling a representative of his church in community activity. His concern for good family living goes beyond the families of his parish. The problems of good housing, playground facilities, good schools, juvenile delinquency, etc., which his community faces are also his problems.

III. What Is the Christian Family?

These are the broad functions of the minister in marriage and family service for which our course seeks to prepare him. But underlying any specific training, there must be an understanding of the family and its place in society and of the peculiar characteristics of the Christian family.

The first of these involves what is covered in good college courses on the family. Certain aspects of it are also touched in courses on Christian ethics and social ethics. Since only 30 class hours are available for our course, it is not feasible to spend very much time on such general aspects. Fortunately, many students enter the theological seminary with one or more such courses completed in their undergraduate work. Others are encouraged to read in this field as a part of their work for this course.

The second involves an exercise in Christian theology. How does a Christian family differ from one that is not Christian? Obviously, the good characteristics of any family—concern for persons, democratic attitudes, love, security, etc.—must also be included as the marks of a Christian family.

The answer to our problem is to be found in the way in which religion impinges on all of life—presuppositions arising from one's conceptions of God and his relation to man, the meaning of these convictions in interpersonal relations, and the activities (such as family worship) which are initiated to foster and express the religious life. The reader will readily see that this presents the student with no mean problem of making his religion relevant to life.

IV. Organization of the Course

With these objectives in view, such a course naturally divides itself into five sections:

- The meaning of Christian family life.
- Marriage and family life education during the 10 years or so before marriage.
- The marriage itself and the problems of developing a creative Christian family life confronted by the young couple.
- Guiding parents in the nurture and training of their children.
- Organizing a church program which gives adequate place to family guidance.

Space permits only the barest mention of the content in these several sections.

The first section is covered in III above. The second, that of educating young people in Christian family life, is most closely related to the present experience of theological students. Most of them are in the later stages of this period of life. Many of them are engaged in supervised religious field work involving leadership of youth groups. In these groups they get experience in conducting such educational activities.

In this period of life, young people may be brought to confront problems of Christian family living as they themselves confront situations and problems in their own families. They can be introduced to the importance of the family in society and helped to establish criteria for Christian conduct in courtship, love and marriage. They can be introduced to studies of factors which make for successful marriage and which help to build criteria for mate selection.

Basic to all this, they may be introduced to an understanding of themselves, including the sexual nature.

Very important to such education in the church is the fact that it is usually given in coeducational groups within which the problems of male-female relationships are already present and in which the standards and ideals evolved may be practiced. Such love matches as are bound to result from these social groups are off to an excellent start because of the common background of the members, both in marriage education and Christian outlook.

The third section concerns itself with the usual problems which must be included in a good marriage course: The adjustments necessary for harmonious and creative living; domestic planning, budgeting, buyman-

ship, life insurance, family accounts; love and sexual adjustment, including the meaning of birth control and planned parenthood; religion in family life.

It is made clear, however, that religious practices are not just added to other aspects of family living. Christian presuppositions and ideals must permeate all the other aspects of life if they are to be worthy of the name.

The fourth section again includes many of the topics which would be found in any course on child study: Making the family unit a wholesome group for the development of personality; discipline; money matters; leisure-time activities; home and school relationships.



How to use
the Bible
in the home?

To these are added the consideration of religion in family life and the way a religious outlook will influence and color all the other topics. Here must come a consideration of how religious faith develops, the answering of children's religious questions, the use of the Bible in the home, the prayer life of the child and family worship, the church relationship of the family and its individual members.

The final section seeks to answer the question of how this kind of family life education can be given through the church. This touches the work of the minister as family counselor, the use of church school curricula which are family-related, program content for young people and young adult groups, library resources and utilization of resources available through family-serving agencies of the community.

V. What to Read

The bibliography for this course is selected from the vast range now available on the family, parent education and child study. It includes non-religious material as well as that prepared more particularly for church use. Among the former are such books as H. A. Bowman's

Marriage for Moderns, F. A. Magoun's *Love and Marriage* and Dorothy Baruch's *New Ways in Discipline*, among the latter Wesner Fallaw's *The Modern Parent and the Teaching Church* and Dora Chaplin's *Children and Religion*.

Bibliographies are selected not only to advance the student's own mastery of the problems, but also to acquaint him with the better material available for his work with church groups.

Audio-visual aids are extensively used, and again with the same two purposes in view. Following are a few titles illustrative of the material used: the *Marriage for Moderns* series, *Are You Ready for Marriage?* (Coronet), *Preface to a Life*, *Human Beginnings*, *A Family Affair*, *At Home with God* and *Litany for a Christian Home*. The last three are filmstrips.

VI. Subjective Results

To make this presentation complete, there should be a section on evidence of the effectiveness of such a course. No study has been made to arrive at such conclusions. Indeed, it is questionable whether reliable data could be secured, because the work of a minister includes work with families in such an integral way that it would be hard for him to trace exactly the sources from which he got the ideas and impetus which underlie his practice.

A recent letter indicates that at least one man is now a member of a family counseling staff because of the start he got in this course in the seminary. Numerous other incidental comments we have received indicate that ministers are finding the course useful.

But in the final analysis we are more concerned that ministers should be prepared to inspire and administer an effective all-around program—including ministry to families where that is called for—than that they should over-emphasize a specialized ministry, important as that may be.



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case-finding in pool halls and taverns

by h. garrick williams

This is the story of eight free blood-test surveys in pool halls and taverns in Jamaica, N. Y., during the summer of 1950. Of 262 persons, 77.5% took free blood tests. This, we feel, is a good response. The other 22.5% had a variety of reasons for refusing a test—"Just had one last week," "Get one on the job every year," "Took my physical for the Army this morning" and "I know I'm all right."

Our experience and preliminary findings have been so interesting that we will continue to use this method as long as it proves advantageous. It makes a free blood test accessible and available to many who otherwise may not visit a physician or clinic for a check-up including a blood test. It affords an opportunity for case-finding and health education in an unorganized group.

It is true some did not participate during any of the eight surveys, but we have had some of the same people who knew they "were all right" ask for a test when next we were in the neighborhood. One was a woman over 60 who said, "I've never been ill a day in my life." She had been thinking about what the loudspeaker said when we were at "Joe's" almost a year before.

Joe's Place was the location of one of the first surveys held. We had been there several times before, but with only a health education program. Each time we had used methods reported in January, 1948, in the JOURNAL OF SOCIAL HYGIENE in an article called "Reaching the People

in Unorganized Groups.” Now, in addition to scheduling social hygiene programs, in cooperation with owners and managers we arrange a two-hour session during which free blood tests are offered.

For the educational phase of the survey we use movies and written and spoken words, the combination of which we hope will propel the audience to want, accept and receive our service.

The spoken words are delivered by the health educator and supplemented by on-the-spot testimonials from satisfied participants. In this field, as in business, a good advertisement is a satisfied customer.

a matter of salesmanship

We are in business—the health education business. One of the products we “sell” is a blood test. Any person who has had a pleasant experience may be asked to give a testimonial. We approach the person with a leading question such as, “The test didn’t hurt, did it, sir?” The attitude of this person is quickly appraised and his answer ascertained before being broadcast on the loudspeaker. (As you well know, such questions can boomerang.) But, we say, ask the man who’s had one.

Added to these psychological advantages which the health educator has to aid him in stimulating the potential consumer is the on-the-spot availability of the service. A person does not have to be stout of heart and willing to seek a private physician or a clinic at an hour or distance which is not convenient. When Wassermann tests are made available “on the house” with a glass of beer or a game of pocket billiards, we are again using the well-established business principle of distributing services to areas where there are consumers.

Stated another way, mere information may not of itself change attitudes. A visual demonstration may have some influence on affecting or motivating the desired behavior.

the team

To do this effectively, some equipment and a survey team of four persons are used. The team consists of:

- A physician known in the community or provided by the New York City Health Department’s bureau of social hygiene.
- A clerk or aide, who records name, address and any other social history desired on the survey record, and the name and number on specimen tubes.
- A projectionist, who shows the movie.
- A health educator, who presents the educational stimuli and explains to the audience what is in progress. This is done by loudspeaker and direct conversation.

Each member of the team has a specific assignment. When it is necessary for one person to do clerical work, operate the projector and serve as health educator, our audience response is less, our "sales" drop and the percentage of participants may be less than 50%.

Volunteers who meet the requirements for one or another of the team duties can be helpful in making a survey run smoothly. This is particularly true when the staff is small. Volunteers can and will do the job when told what is expected of them, what is to be done and how it can be accomplished.

gooseneck lamps and loudspeakers

The equipment is made available by the New York City Health Department and the Queensboro Tuberculosis and Health Association.

The Health Department provides sterilized blood-letting needles in individual envelopes, 70% alcohol, cotton balls, one-half dozen syringes, small bore needles, a tourniquet, a small bottle of aromatic spirits of ammonia, a roll of white paper, and survey record forms. The Tuberculosis and Health Association provides two gooseneck lamps, extension cords, two card tables, a microphone, a movie projector, two loudspeakers, leaflets, any publicity requested for promotion of the survey, and two large paper bags for the disposal of trash.

The gooseneck lamps may be needed to better illuminate the small areas used by the physician and clerk. The folding tables are necessary because some places have tables which are too high or the space around them may not lend itself to comfort when a blood specimen is taken. The white paper is used to cover tables used by the clerk and physician. The paper bags aid in keeping the area neat and facilitate a quick clean-up when the survey is concluded.

no sterilization equipment

It has perhaps been noted that no equipment is listed for sterilizing needles and syringes. This is not necessary because the physician uses a different blood-letting needle for each person. The needles are sterilized and packaged in individual envelopes. They are used but once at a survey.

The syringes, likewise previously sterilized, are used but once at a survey and only when the physician thinks it advantageous. In each survey not more than two or three persons may require a syringe.

Thus, the procedure and equipment for a free Wassermann survey in a tavern or pool hall does not differ basically from an industrial or community survey. All blood-test surveys seek to find syphilis—new cases, cases previously unknown.

A major variation in program procedure is the use of short, entertaining films at intervals throughout the two-hour period of the survey.

Participation in a survey is entirely voluntary. There is, of course, concern on the part of a well-organized survey team to use to the fullest extent those factors which will increase participation.

ways to encourage response

- We arrange for the owner, manager, bartender or any other person with a following to get the line started—actually participate. Others present follow the leader.

- We present a short “commercial” over the loudspeaker at frequent intervals to keep the audience informed as to what is in progress. The audience may change completely during the two-hour period.

- We emphasize a single idea, simply stated in each short message.

- We present entertaining films which must be snappy or feature a personality popular with the audience. Obviously, a recitation of the Gettysburg Address is not the best offering. Popular songs, dance groups and cheesecake better fill the prescription.

- We see that each member of the team does his part to make the survey function smoothly and to give the appearance of a well-organized group.

- We use the second loudspeaker near the front door of a tavern or pool hall.

- We select a date which does not conflict with a big sports event in which large numbers of the audience are interested. (The only exception to this rule occurs when a brief educational program is given before the sports event starts.)

- We use short VD films with simply stated messages, such as the Columbia University Communication Materials Center’s VD sports series—, with Mel Allen, Jackie Robinson and Joe Louis.

- We distribute VD leaflets to the audience. Leaflets—such as the American Social Hygiene Association’s “Questions and Answers about Syphilis and Gonorrhea”—should be distributed at a place a few days prior to the survey. Beatrice G. Konheim and Dorothy Neuhoﬀ Naiman reported in April, 1951, in the JOURNAL OF SOCIAL HYGIENE that they had found this pamphlet effective with a parent group.

When all of these precautions were fully observed, the participation of the audience was greater. However, a 40% response was obtained when the entertaining films and the educational films were spliced together for a continuous run with no break for “commercials.”

Table I

Response of Pool Hall and Tavern Audiences to Blood-Test Surveys

Survey	Number of Specimens	Size of Audience	Per Cent Response
B	15	23	65.2
C	10	25	40.0
D	22	26	84.6
E	23	31	74.2
F	47	47	100.0
G	32	37	86.4
J	37	48	77.1
K	17	25	68.0
TOTAL	203	262	77.5

The response of audiences in a pool hall or tavern is of interest to the health educator because he is concerned with the problem of motivating individuals and groups to act positively for health or the health product he "sells." The value of this individual and group response is observable in results of the serology surveys. Before results of the test are given, the basis of interpretation as suggested by the Department of Health should be stated.

Three tests were used—the Mazzini, Kolmer and VDRL.

The Mazzini test was used to screen all specimens. Any positive reactions were then tested with the Kolmer and VDRL.

All of the serologies were considered significant when:

- The Kolmer was 3-plus or better, or
- The VDRL was 1:2 or better, or
- The person was previously known to the Department of Health, or
- The person was not over 30 years of age. This criterion of significance was also applied when the Kolmer and VDRL were weakly positive.

There were 203 specimens tested. Thirty-four of these gave a positive reaction on the Kolmer or VDRL or both. Thirteen were only weakly positive, but four of these were considered significant because of age. However, three persons who had a similar serology and returned to the clinic for further examination were found to be *no case*. One weakly positive reactor was over 30 years of age but considered significant because of a previous record.

Fisk University graduate.
 Director of Special Districts,
 Queensboro Tuberculosis
 and Health Association, N. Y.
 H. Garrick Williams.



Table II
 Number of Positive Reactions by Survey and Interpretation

Survey	Number Positive	Positive on Kolmer or VDRL	Weakly Positive Kolmer or VDRL Sig- nificant Because of Age	Weakly Positive Serology and Over 30 Years of Age*	No Sig- nificant Positives
B	0	0	0	0	0
C	3	0	2	1	2
D	8	6	1	1	7
E	7	4	0	3	4
F	12	7	1	4†	9†
G	3	3	0	0	3
J	1	1	0	0	1
K	0	0	0	0	0
TOTAL	34	21	4	9	26

* No special follow-up indicated.

† One specimen significant because of previous record although over 30 years of age.

Twenty-one were positive on VDRL or Kolmer or both. Thus, if we combine all respondents who met one or more criteria of significance, there were 26 (12.8% of all tested) who gave a positive reaction.

no generalization

Because of the limited sample we cannot make the generalization and do not wish to imply that findings are always high in a pool hall and tavern audience. It should be noted that Survey B, in a pool hall, and Survey K, in a tavern, discovered no positives. The small numbers who participated at these two surveys cannot be indicative of too small a sample, for it will be observed that Survey C—with the smallest number of participants of any of the eight surveys—discovered two positives which met the measure of significance.

Table III

Number of Positives with or without Previous Records

Survey	Number of Specimens	Previous Record		Total
		Known	Previously Unknown	
B	15	0	0	0
C	10	0	3	3
D	22	1	7	8
E	23	2	5	7
F	47	1	11	12
G	32	2	1	3
J	37	0	1	1
K	17	0	0	0
TOTAL	203	6	28	34

Six of the positives were previously known to the Department of Health. Twenty-eight were not known, and 20 of these are appraised significant.

Table IV

Age, Sex and Marital Status of Positive Reactors

Age Range	Female		Male		Total
	Married	Single	Married	Single	Male & Female
15-19	1	1
20-24	1	1	..	1	3
25-29	..	2	1	1	4
30-34	..	2	2	3	7
35-39	5	3	8
40-44	1	..	1
45-49	..	1	1	1	3
50-54	..	1	3	..	4
55-59	2	1	3
TOTAL	1	7	15	11	34

The youngest positive reactor was a boy of 15. His father stopped a few minutes to see the movies, listened to the health educator and read a leaflet. Finally he approached a member of the survey team to ask whether, if he brought his son to the survey, we would give the boy a test.

The other positives were not minors. In an article in March, 1951, in the *American Journal of Syphilis, Gonorrhea and Venereal Diseases*,



*age is no
guarantee
of immunity.*

Godias J. Drolet observed that while new syphilis cases among women are found mostly among the younger group, among male patients a substantial proportion are older men. Twenty-two of the 26 male positives were 30 or over—while six of the eight females were 31 or under. Married males outnumbered single males, but single females outnumbered married females in the positive group.

Table V
Age, Sex and Marital Status of Negative Respondents

Age Range	Single		Married		Total
	Male	Female	Male	Female	
15-19	27	3	..	1	31
20-24	24	6	3	3	36
25-29	15	2	3	5	25
30-34	17	2	6	6	31
35-39	4	1	9	2	16
40-44	3	..	10	1	14
45-49	3	..	5	..	8
50-54	3	..	2	..	5
55-59	..	..	..	..	..
60-64	..	..	1	..	1
65-69	..	..	2	..	2
TOTAL	96	14	41	18	169

The age-sex distribution of negative respondents shows that we are surveying a predominantly male population group, as would be expected. Single males outnumbered single females almost seven to one, while married males outnumbered married females about two to one.

In the combined negative and positive groups there were 163 males and 40 females. Of the 21 single females who participated seven, or one-third, had a positive serology. Only one of the 19 married females was positive.

Of 107 single males there were 11 positive reactions, while 15 positives were recorded among 56 married males.

Even though eight of the positives were considered insignificant, the total findings are higher than recorded for general population surveys.

No effort is being made here to include results of follow-up. We know that all positives were contacted by letter and the significant positives have had some additional follow-up.

it was worthwhile

From an aggregate audience of 262, in eight surveys, 203 persons participated. There were 26 tests considered significant, 20 of them previously unknown to the Department of Health.

It seems, therefore, that free blood-test surveys in pool halls and taverns have merit even though some places may yield no positives. The method has definite health education value.

Participation in a survey may be influenced by several reasons, but accessibility is of tremendous importance.

The experience gained in these surveys indicates need for further study and research into the factors which influence a person to get a blood test.

I should like to conclude with a word of thanks to Dr. Fannie Tomson, health officer of the Jamaica Health Center, and to members of her staff for helping to make these surveys workable.



*one-third of the
single women
had positive tests.*



off-limits . . .
and the
heat's on!

*facts you should know
about*

the joint armed forces disciplinary control board

Roll into one bundle representatives of the health department, police, courts, Liquor Control Board, American Social Hygiene Association and Army, Navy, Air Force, Coast Guard and Marines—and what do you have?

Joe, a tavernkeeper, can tell you now. He'd say, "The Joint Armed Forces Disciplinary Control Board." But a few months ago he laughed it all off as a huge joke. . . .

Sailors and factory workers elbowed his bar as he spoke. "Look, Bob, we got a Letter of Warning. Joint Disciplinary Control Board—who ever heard of them? Anybody want a good look at this scrap of paper before I throw it away?" Waving the warning letter for all to see, he was answered with derisive hoots.

"A bunch of crackpots," Bob, his bartender, jeered as he poured a drink.

"Yeh, long-nosed busy-bodies," somebody added.

One sailor looked serious. "You know, Joe, that warning's not so funny. Better watch out. Those busy-bodies can put you off-limits. You can lose plenty of money."

"Off-limits, on-limits, who cares. I got a connection. One letter from him and they'll be shaking in their shoes."

"That's right. It ain't what you know, but who you know," the bartender said, while he continued to fill them up for the servicemen standing around the bar.

Joe ignored the warning.

What if he had B-girls—what if "hustlers" were on hand—what if "chippies" hung out there—what if minors were served—what if everybody got plastered—he had to sell drinks, didn't he? Sure, the place was dirty here and there. It had been dirty for 10 years. It was clean dirt. His customers didn't complain. Just these buttinskies. "Disciplinary Control Board!" Joe snorted in a fine show of scorn.

He and a lot of others like him thought all you had to do was pay no attention. Let them take care of their soldier boys and let hard-working civilians alone.

no hitlers, the boards

What Joe didn't realize was that this was just what the Disciplinary Control Boards would like to do. The safety, welfare, health and discipline of the "boys" are of prime concern. The boards don't want to interfere with purely civilian matters. If military personnel do not frequent a place, they leave that place alone, whatever its condition.

But if the health and welfare of servicemen are in any way adversely affected, the local military commander first warns the offending establishment—to give it every chance to set things straight—and tells the police and health departments of the situation.

Never except in an emergency do the boards pull their rank and parade their authority. Always they desire community cooperation for the ultimate benefit of all. Never except in an emergency do they put a place out-of-bounds without considering all the facts and giving the owner or manager a chance to present his side of the case.

joe before the board

For 10 years Joe had run his barroom in his own way, with only an occasional health department check-up of sanitary conditions, and perhaps with many strategically distributed gifts to the "right people."

Some time after he had received the Letter of Warning, he found in his mail an invitation to appear before the local Disciplinary Control Board. He was getting a little tired of this annoyance. It warmed the cockles of his heart to think of the letter from his connection that he would flaunt before their faces and their shamefaced retreat before this evidence of his "pull."

When the day comes Joe dons his best suit and appears before the board, a cocky figure, not at all fazed. He casts a discriminately scornful

*the asha sends
a representative
to board meetings.*



eye on the group—a Navy commander, an Air Force colonel, an Army captain, the chief of police (friend of his), the mayor (another friend), the health officer, and a man he doesn't know (turns out to be a representative of the American Social Hygiene Association). Joe learns the ASHA man attends meetings of the board to advise about prostitution and venereal disease control. He and the other civilians are not members of the board but are invited there for their cooperation and advice.

"Well, I got here," Joe blurts it out as though he were conferring a favor. "What's this all about?"

The president of the board points out that while he has received a warning, investigations show he has done nothing to remedy matters. "We have written and signed reports here to prove you haven't done a thing to clean up your place. Now, we don't want to interfere with your business, Mr. Haynes, if you will agree . . ."

Joe doesn't believe in patience when he has the upper hand.

"I've got a letter here from a good friend," he interrupts. "You'll recognize his name when you hear it. I'll read what he writes. 'I've known Mr. Joseph Haynes for 20 years, and I have always found him to be a public-spirited citizen. The serviceman has a real friend in Mr. Haynes.' That's me," says Joe. "You can read it. Right here it says it."

"Well, that's fine, Mr. Haynes. We appreciate your friend's interest and his belief that you are a public-spirited citizen. If such is the case, why have you made no effort to clean up your place? Unsanitary conditions, B-girls, prostitutes and 'chippies' consorting with servicemen, three fights within the last two months in which servicemen were injured—that's not a pretty record. We want your place to stay open, but not as a place for pick-ups. You can understand that, Mr. Haynes."

Joe still managed to look cocky, but his voice gave him away. Ten years of self-sufficiency were beginning to crumble. "What do you expect

me to do? Baby the men? I can't control your men—I can't listen to everything they say, stop every blow before it falls. Nobody can do that. I run a good place, never had any trouble until the servicemen came along."

The mayor stood up. (The board encourages civil authorities to take part.) "I'm sure Mr. Haynes means to do the right thing for the servicemen. The matter just hasn't been presented to him in this light before. Perhaps if we give him another chance, he . . ."

When Joe heard the mayor coming to his defense, he was on familiar ground. "Your Honor, let them put me off-limits. What do I care? It's a free country and nobody is going to tell me what to do." He picked up his hat with a flourish and walked out.

His place was unanimously voted to be placed off-limits. So unsanitary and so unsavory were conditions there that it was decided to refer the problem to the health and police departments.

Normally an establishment remains off-limits 90 days. If Joe does an about-face, he can present his case before a later board meeting and expect a favorable decision.

all hands joined

Joint Armed Forces Disciplinary Control Boards meet periodically all over the country to review matters detrimental to the Armed Forces which are presented to them by local military commanders. The scope of their work is practically limitless. They cooperate with and supplement character guidance programs of the different military services. They work with civil advisory committees, local law enforcement groups and health departments to bring about clean-ups and discuss policies for improving conditions.

They serve as boards of hearing available to the general public, never as courts, never pressing charges. The American Social Hygiene Association's representative gives them the benefit of ASHA's long years of experience and up-to-the-minute data on prostitution and allied conditions.

The boards are meeting-places for all those agencies interested in the welfare of servicemen—their recreation, housing, health. Vice racketeers can well scurry for cover when their activities are scrutinized.

The weapon of the boards is the off-limit restriction. Sometimes it is difficult to convince communities of the real power these boards wield, but like Joe, they frequently learn in time that ignoring warnings doesn't work.

One board persistently invited the police to sit in and hear the facts about commercialized prostitution activities and other conditions detrimental to the health and moral welfare of servicemen. Stubbornly the

police refused to attend board meetings. But at last some policemen, at the behest of the mayor, accepted the board's invitation. They sat there in their smart uniforms, an impassive, staunch-looking lot, uttering not a word. Their stolid expressions bespoke their contempt for the whole set-up. When the meeting adjourned, they filed out. That was all.

the growing pressure

Yet little by little the people in that community began to feel the weight of the board's power. Many spots were being placed off-limits, operators were beginning to feel the pinch when defense money was no longer rolling in. Protests were being made to the mayor. "Connections" disappeared. Racketeers for the first time in 50 years were experiencing a rival force superior to their own.

Then the local press cracked down on the embattled but still struggling vice interests and their political satellites. A strong abetting force was the Social Hygiene Society, which wanted all to know the conditions to which servicemen were being exposed.

An indifferent, lethargic citizenry was rousing itself. A new order was being born.

Here and there throughout the country communities like this one are shaking off the shackles of the underworld, developing a social conscience, reforming local government—and these boards are encouraging them.

harry davis knuckles down

Harry Davis, manager of the Ritz Bar, was another who looked with a jaundiced eye on the board until he learned from costly experience that an off-limits sign could ruin his business.

A B-girl who had at one time received a cut from him for forcing drinks on customers, "rolled" a serviceman for \$400. The serviceman had met her at Davis's bar.

Davis stood with dignity before the board, well-tailored, well-barbered and well-spoken.

"Yes," he answered a question, "I did have a few B-girls working for me. But not since my license was restored."

"Mr. Davis, can you tell us what precautions you have taken to make sure your place is an orderly one?"

"My business is to sell liquor," he stated. "I want things to run smoothly. I've paid the price. I won't stand for any rolling or knockout drops or anything of that kind. Of course, things are bound to—er—crackle, shall I say," he produced a slow smile, "when you get a lot of servicemen and civilians drinking together."

“What is your procedure then?”

“I let the Military Police and Shore Patrol inspect my place at all times and I let them handle any problems that arise. I personally see that my place is run the way you want me to run it. My manager, my bartenders, my waitresses are instructed to report to me anyone and anything that doesn't look on the up and up to them.”

The board knew Davis's business had suffered. They knew he didn't like the black mark of the off-limits sign which stood like a warning beacon for all to see on his wall, which drove away service personnel in uniform and which tempted some to come back disguised as civilians, inviting more trouble for him.

The board believed Davis intended to cooperate and they voted to remove the off-limits restriction from his place.

a jolt is in order

There are communities that have always had a line of brothels, have always had gambling. It's part of the age-old mores of certain sections. A political bigwig boasted of the attractive “line” in his town. “I've gone up and down it myself. A man isn't a man otherwise.” And the citizens for the most part go along with him.

There are communities whose political and police officials are so inured to the *status quo* that they are blind to the fact that other towns have cleaned up. When they are made to realize that they themselves are not going along with the current stream of social thought, they have the wit to raise their sights.



*some communities
think she's a
necessary liability.*

There are communities whose citizens are dulled in conscience and judgment by the seeming futility of protest, by their outworn philosophy that politics and rackets are inevitable blood-brothers, that prostitution is as necessary and desirable as a drainage basin. These citizens have been jolted by newspaper headlines (often sparked by the American Social Hygiene Association) to throw out their corrupt officials and elect honest reform governments.

There are communities which cooperate, which are immeasurably improved by the interest and action of the boards, which are grateful to them for their intercession. All barroom proprietors are not "Joes" nor "Davises." Some don't realize the implications of their *laissez-faire* ways until they receive a Letter of Warning. Others sincerely don't know of the existence of an incident until they are notified.

a whole city

If law enforcement is so lax, if violations are so widespread that investigation of individual cases would drag on for years, if vice interests need only move out into a neighboring area to continue their activities unmolested, drastic measures are necessary. In such a case, the board may recommend that a whole city or a part of it be placed out-of-bounds.

In a city where pockets are bulging with GI money, where business is pretty bad without it, this is a catastrophe. No more effective method could be used for booting out the underworld and dislodging corrupt officials from their berths.

After one notorious street in a community frequented by thousands of sailors had been placed off-limits, the conduct of service personnel was phenomenally improved. VD rates tumbled, not one arrest was made by the Shore Patrol, gambling and illicit whiskey disappeared in that area. The cooperation of city authorities played no small part in the change.

When a Chamber of Commerce exerts every influence to promote the establishment of an army camp in its area and the government accedes, it is up to that community to examine its way of life to be sure it will be a fit place for service personnel, who come from all manner of places, some of which have repressed gambling and commercialized prostitution.

The military owes the parents of all men assurance that they won't be dumped into a well of corruption. Even if a community condones vice—despite a state law which forbids it—that community must change its ways if it wants the money of the GI.

prostitution

The boards are particularly eager to have experts talk to them on policy questions. The American Social Hygiene Association's field repre-

representatives can speak with authority on the suppression of prostitution. Experience shows that where open, flagrant prostitution exists, VD rates are usually relatively high.

At a board meeting a public health man lashes out against light fines. "The fines are too small. Prostitutes pay them and go their way until they're picked up again. Prostitutes descend like locusts on a community where fines are light. The police are helpless until they're provided with adequate laws and court cooperation."

The social hygiene representative concurs. "To fight prostitution you've got to get the offenders into the courts. If after all your work the courts levy small fines, such fines are regarded as licenses by prostitutes."

"When word gets around that a section is going to be flooded with servicemen, the prostitution racketeer makes every effort to get an inside stake in the service payroll. The more prostitutes, the more work for the police department.

"We've got to head this off before it starts. Newspaper publicity is one of the answers."

A police captain speaks up. "We've a law against pandering, but it's hard to prove. I've convicted only one man in 10 years, and that was because he convicted himself through his own admissions.

"You have to prove the man received money from the prostitute. Concerning affidavits, if a soldier is involved, he is frequently shipped out before the case comes to trial. There is no one to testify, no evidence—and the case is thrown out of court."

"It's my opinion," says a military official, "that the big problem in pandering is the bellboy and the cabdriver. We could place certain cabs and hotels off-limits to military personnel."

With each man a specialist, each approaching the problem from a different point of view, discussion is lively and the final decision is sure to represent a synthesis of thoroughly considered opinion.

your marriage certificate, please

In competition with the brothel is the tourist cabin, offering a maximum of privacy and a minimum of involvement. Frank Alpine, the not-too-prosperous manager of the Green Gables Cabins, appeared before a board meeting with a Letter of Warning concerning alleged prostitution.

Shifting nervously from one foot to the other, he plunged into his story. "We used to accept any couple who said they were man and wife. Now, if a soldier or sailor with a woman asks for a room, we look to see if there's any baggage or children. If not, we ask to see their marriage certificate. They don't like it, but we don't want any trouble."

It isn't the permanent guests, families with children, who give him difficulty, but the couple who may or may not stay as overnight guests. He says he hasn't taken any taxi business since he received the Letter of Warning.

"You see, all the trouble started with a young runaway. One of my employes let her and her boy friend in."

After a Shore Patrol officer testified that no servicemen had been apprehended there since the warning letter, the board decided that Frank Alpine's place would remain on-limits.

local health standards

Health standards vary from community to community. Sometimes they are decades behind comparable military standards. Once the military intervenes, the health of every one is benefited and health regulations and enforcement improve.

The case of the Indian Cafe is an example of cooperation. Water from the cafe was tapped into another store's line. When the city found it out, it had the water shut off. The cafe still operated—without running water!

It was placed off-limits to military personnel. The city health officer reacted promptly.

"We can't allow an eating place to operate without running water. If the place isn't sanitary enough for servicemen, it's not good enough for our citizens, and we'll get it clean or close it to everybody."

*the minor needs
food, not liquor.*



In another city it took a death from knock-out drops to get a dilatory police department on its toes. Supercilious toward the board, the police were shocked into action when the papers carried the story in blazing headlines. Once the clamps were put on the prostitution racket, VD rates plunged. The newspaper publicity underscored the previous efforts of the board to get police cooperation, and the recommendations of the board from that time on assumed a new weightiness with the police.

Incidentally this police department is not typical, although its counterpart can be found wherever sluggish civic conscience exists.

liquor, airplanes and shacks

Let it not be thought that Armed Forces Disciplinary Control Boards confine their attention to vice and sanitation. The sale of liquor to minors and to people who have already had too much to drink is another matter boards consider. Even airlines are put off-limits if their safety precautions are so lax that servicemen's lives are endangered. Where military families are housed in shacks and gouged by landlords, boards face the problem of improving living quarters for servicemen and their families.

tying it up

The Joint Armed Forces Disciplinary Control Boards don't think of themselves as reformers or pressure groups in the usual sense. Nor do they all function in the same way. But they all have the same job to do for servicemen. Some may do it more efficiently than others; none can do it alone.

They know an off-limits sign means little unless Shore Patrol and Military Police post a place. They know they can achieve better, more lasting results if authorities are sympathetic. They know that once they win popular support, their job will be lighter, the Armed Forces will be stronger, and towns will be healthier.

Social Hygiene Day Theme • • •

- ★ *Prepare young people for national service*
- ★ *Protect young people from VD and vice*
- ★ *Preserve family life*

a social
hygiene
worker
in alaska



frontiersman with a mission

by elizabeth b. mcquaid

Spending three days and nights on the impacted snows of the isolated Bering Sea coast sounds more like an Eskimo's vacation dream than training for a social hygiene worker. But to middle-aged Raymond P. Sanford, deceptively slim, with the tough stamina of a trained athlete, these Arctic rigors were a challenge and an opportunity in his efforts to stamp out venereal disease and prostitution in a land of lonely military outposts and frontier towns.

The three-day vigil taught airmen and officers how to care for themselves in the event of a forced landing. It was the final test for a passing grade in the survival course conducted by the Air Force's Arctic indoctrination school.

Thirteen preparatory lectures showed Sanford how to snare rabbits, signal for help, eat in the snow. Then he was dragged on a sled to an expanse of ice by the Bering Sea and left there, in a simulated forced landing, with one companion. Equipped with rat-tailed snowshoes, nylon parachute cloth and cords and yellow and blue tarpaulins, they built a nylon and tarpaulin shelter over a skeleton of snowshoes, and there spent the night. The yellow side of the tarpaulin flashed one signal to aircraft, the blue another.

On the second day with the help of a third man they dug a tunnel seven feet deep leading to a pit seven feet in diameter where they spent a second night. The next day they sawed out hunks of ice to build an igloo.

"There's something about that icy quiet that gets men. Some crack up during the night. They have to be removed." And Sanford's eyes lose their matter-of-factness for a moment as they remember. "You get a strange feeling lying buried there with nothing but ice and silence all around you. . . ."

Dramatic and heroic it certainly is. But what has it to do with that conventional, antiseptic-sounding term, *social hygiene*? Sanford, a field worker for the American Social Hygiene Association, has several excellent answers ready for this question.

forearmed

In traveling to military bases he was obliged, like Air Force personnel, to fly over remote reaches of ice. To be permitted to fly, he had to pass the Arctic Survivor course. Carrying full Arctic equipment for any emergency and possessed of the know-how, he could take care of himself and be a burden to no one. Then, too, he learned the language and had the experience of a select group—the Arctic Survivors, and needless to say, new recruits more readily listened to his message.

His social hygiene message he regarded with missionary zeal—to impress upon as many groups as he could, both military and civilian, the necessity for using sex rightly, if prostitution and venereal disease are to be wiped out.



the snow and cold
lie all about you.

To reach the GI (and Sanford did reach him—2,700 in one month at Ladd Air Force Base alone), he used the GI vernacular and appealed to the mechanical interests of the men to illustrate his points.

more than a paint job

He likened the human body to an automobile. Just as the family car must have the right proportion of air, good gas and electricity to run in a regular rhythm, must have its tires inflated, must be driven only by a licensed driver subject to such restrictions as the narrowness of the road, traffic signs and police regulation, so must the human machine be equipped and controlled to run in the proper fashion, subject to many restrictions, if it is to function efficiently and if the happiness and safety of others are to be assured.

Sanford no doubt got a smile from his GI audience when he told them, "You don't just look at the paint job when you buy a car. You want the engine to stand up and run properly. The paint job may be super, but 'I can't give you anything but love, Baby' isn't the whole story of marriage—not by a long shot."

To those who said that uncontrolled sex conduct was natural, Sanford answered that nature is no criterion for conduct—it is natural for self-protection to run on the battlefield. The soldier stands his ground.

dates can be patriotic

He told the serviceman that anything that undermines personal integrity and the welfare of the group undermines the purpose for which they are fighting. It is not enough to be a good fighting man unless one can be patriotic on a date too. Just as one soldier can command only one little sector, so one person can deal with only one other person at a time. One's real love for one's country can be determined by one's conduct with others, and if a soldier leaves one girl "better off," then America is that much better off.

the eskimo

Sanford cautioned the serviceman not to take advantage of a traditional kind of limited promiscuity that Eskimos have long indulged in for race survival purposes. (It is not known how prevalent this practice is today.) He found that Eskimo girls succumb to the importunities of servicemen and civilians as readily as they do to the white man's diseases.

To attract servicemen some tavern keepers encourage Eskimo girls to stay around by plying them with drinks. These girls, infiltrating into the larger cities, without industrial training of any kind, indulge in promiscuity in return for drinks and clothes. They do not accept money.



chaplain (captain)
robert w. lankford
supervises collat-
ing and binding of
social hygiene
pamphlets.

"Gallantry is new to them," explained Sanford. "Some of them say, 'Well, he was nice to me and I liked him.'"

Eskimo U. S. Coast Guardsmen, the eyes and ears of our Bering Sea defense, are just as much interested in lectures and films on sex education as are the men from the States. One group at Nome amazed their commander by staying long overtime to see VD movies and ask questions.

sex and prostitution

Attitudes toward sex education in Alaska, Sanford revealed, are diversified, contradictory, sometimes Victorian and often amusing.

At a large convention of an Alaskan patriotic organization everything was done to prevent Sanford from getting the floor. The delegates could not endure the insertion of the word "prostitution" in a resolution that would be read before both men and women. Such delicate sensibilities, however, found nothing indelicate in wide-open red-light districts. Doubtless these delegates erroneously considered them a hygienic protection.

During a conference with the mayor of a town important to the Armed Forces, Sanford showed him a report. It was a well-documented survey by the American Social Hygiene Association of the town's flagrant prostitution conditions. Sanford pleaded for the service personnel and the town's young people when he asked that the territorial laws be enforced to close down a red-light district that harked back to gold rush days. Reluctantly the mayor agreed to give the closing order, but warned Sanford that public opinion would not support the move.

That mayor was a courageous man. Sanford was more courageous.

Recognizing that enlightened public opinion was basic to any permanent reform, he set about making the people of that community more conscious of their social obligations.

Just two weeks had passed when the chief of police called Sanford aside. He was in dead earnest as he looked Sanford straight in the eye.

"The racketeers are out to get you. You've interrupted their business. There have been three murders in this town, and I don't want a fourth on my hands."

"Chief," said Sanford cheerfully, "there's one thing we may as well understand between us right now, and that is that Sanford is 100% expendable."

And he kept right on with his popular educational campaign against the prostitution racket.

Sanford grinned when he recalled the wife of a military figure who objected to a social hygiene book's being placed on a special library shelf for parents.

"In deference to her the book was taken off that shelf and placed on the 'sociology' shelf. There it apparently lost its objectionable qualities, for the lady made no further protest."

Even school authorities can be reluctant. After spending five hours talking to a high school principal and a PTA president about the necessity for family life education, Sanford at last prevailed upon the PTA president, who usually exercised a hands-off policy, to request a film showing for parents.

they want pamphlets

Despite such uphill work, Sanford, systematic organizer that he is, frequently met an enthusiastic response to his well-planned approaches.

So eager were the Alaskan sea frontier bases and ships for social hygiene pamphlets for every service library in the entire field that they were willing to collate and bind the material themselves. Civilian libraries are also using these bound sets.

One advantage to such an over-all plan was that Sanford or any radio broadcaster or lecturer could cite a volume and page as a reference available in the public library. Thus interested listeners could find further reading material without difficulty. Doctors could look up medical and legal aspects of sex problems which Sanford could merely touch upon in his talks. Ministers told one another about these sets and used them as guides in working out some of their problems.



fort richardson troops
try their hand
at trout fishing.

this and that

Sanford's subsidiary duties were not restricted to library work. His amazing physical energy sought outlets in diverse directions—he was a publicity man, public health worker, educational adviser.

In one city Sanford successfully propped up an almost defunct health organization by securing radio time, a speaker, references for the speaker from the JOURNAL OF SOCIAL HYGIENE, and plenty of newspaper publicity for the program.

He showed films before the Nome Chamber of Commerce, which asked him to return.

He provided a high school principal with mimeographed information on summer social hygiene courses which most of the teachers could not hope to attend, because the principal thought his teachers might thus understand more clearly the significance of social hygiene.

"You have to approach women's groups cautiously," warned Sanford.

Sanford described a precautionary technique of his for gaining entree into a women's club. After first getting the approval of a health organization executive, he called the president of the club just before the meeting and asked permission to speak for three minutes. Buttressed by the health department, he could hardly be refused. He stressed national defense, limited himself to just three minutes and only partially answered the women's questions.

"This way, they always want to hear more," he said.

the serviceman

It was his work, however, with the Armed Forces that brought a gleam to Sanford's eye. Only a "regular guy" can put moral lessons across to the GI. A holier-than-thou tsK-tsker would be booed off the base.

Sanford was never too busy to do the little things that seem big to the GI. These were the things that made servicemen feel he was their friend, the things that won respect for him and the way of life he represents. Since fishing and hunting are the favorite sports of the Alaskan, Sanford learned to spear a salmon in order to teach the airmen how.

"Ever hear of fishing by hydrostatic shock?" he asked. "You watch a fish disappear beneath an undersea boulder. You drop a rock on the boulder. Then just reach for the stunned fish."

It sounded wonderful and the airmen loved it.

On the serious side, he presented films to students of the Arctic indoctrination school, featured recordings on penicillin and VD control at base dispensaries.

He can tell you strange things like seeing mosquitoes flying in a snow storm . . . like turning on the water tap during earth tremors, which are frequent in Alaska. He says all Alaskans do this to test the severity of the shock. If the water pipes are broken, it is no light tremor.

Sanford knows Alaska and he knows his job. To do that job required plenty of grit and zeal, which is what one public-spirited citizen meant when he tugged at Sanford's lapel and in a burst of honest enthusiasm said, "Well, if there's anyone around here who deserves a commendation, it's this man."

Note: After nearly three years on this important assignment in Alaska—with all the hardship and absence from his family it involved—Mr. Sanford has been recalled to duty in the States.

CREDITS

Extension Service, Union County (N. J.), p. 145, p. 149

Laurel Studio, p. 151

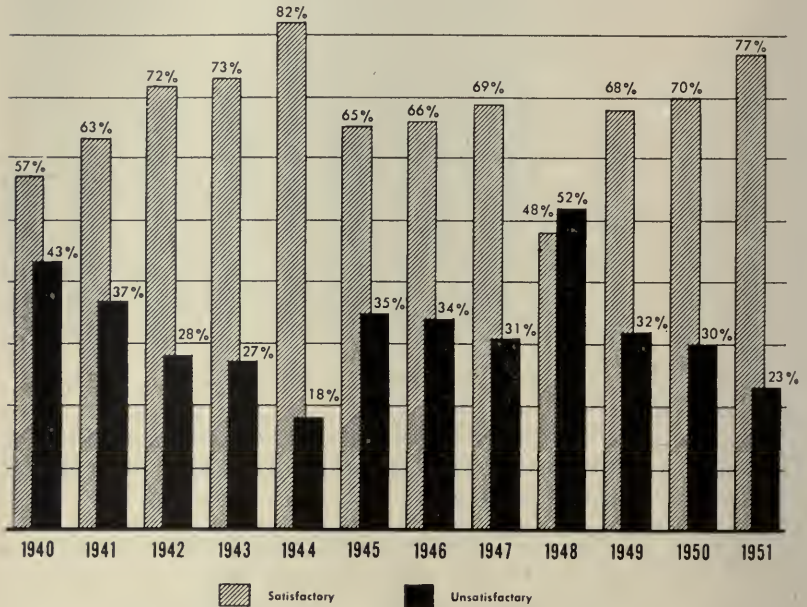
Yale University News Bureau, p. 159

National Film Board of Canada Photo, used with the permission of the Health League of Canada, p. 160

Department of Defense Photos, p. 177, 179, 180, 183, 184

Army Times, December 29, p. 192

PROSTITUTION CONDITIONS IN THE U.S.A. A 12 YEAR SURVEY



Vice Racketeers Lose Ground

"America is winning the long fight against commercialized prostitution," Dr. Walter Clarke, ASHA's executive director, declared recently in a statement summarizing studies of prostitution conditions last year.

He noted that according to the American Social Hygiene Association's surveys of 228 cities there were fewer communities with open and flagrant prostitution in 1951 than at any time since 1940 with the single exception of 1944.

Dr. Clarke pointed out that each year ASHA surveys from 200 to 250 communities, including all those near important military installations and all large cities in the country, to ascertain the amount and fragrance of commercialized prostitution.

ASHA classifies conditions as satisfactory or unsatisfactory on the basis of three factors:

- The size of the community.
- The amount of prostitution discovered during the survey.
- The fragrance or accessibility of prostitutes.

"I want to point out that our statements on our findings report conditions at the actual time of the survey. We vouch for their accuracy only as of that time because prostitution conditions frequently change almost overnight from unsatisfactory to satisfactory—or vice versa—as a result of law enforcement or lack of it," Dr. Clarke emphasized.

He said that ASHA's field representatives (an entirely different group of workers from those who conduct the surveys) follow up the surveys by visiting each community to compliment the leaders of those enforcing the laws against prostitution and to urge the leaders of those tolerating unsatisfactory conditions to correct those conditions promptly.

"Usually when we succeed in bringing about enforcement of anti-prostitution laws, the enforcement of liquor, gambling and other laws also improves," Dr. Clarke added.

ASHA's field workers give special attention to communities feeling the impact of military or industrial mobilization.

Since 1948

Dr. Clarke said, "It is encouraging that so much progress has been made since 1948 when the American Social Hygiene Association stepped up its social protection activities. During World War II there was a national team—the Federal Security Agency's temporary social protection division, the Public Health Service, the VD control divisions of the Army and Navy, and ASHA—to fight prostitution and VD.

"Only in 1944 did this powerful team, spending many times the total present expenditures of the American Social Hygiene Association, bring the number of cities classified as having unsatisfactory prostitution conditions to a lower level than that reached under ASHA's leadership in 1951 . . . as indicated in the chart.

"Since 1948 the success of our social protection activities has clearly indicated the generally cooperative attitude of local authorities and voluntary agencies in responding to ASHA's leadership," Dr. Clarke concluded.

Funds for ASHA's social protection activities—as for all the Association's national defense work—come from voluntary contributions made by citizens through their Community Chests to the United Defense Fund.

SOCIAL HYGIENE DAY

Regional Conference in Los Angeles

Dr. A. J. Carlson, dean of American physiologists, will be the principal speaker at a regional conference in observance of National Social Hygiene Day April 23 in Los Angeles.

He will discuss the question, "Can syphilis and gonorrhea be eliminated from the human race?"

Ernest Boyd MacNaughton, prominent Oregonian, will be awarded the William Freeman Snow medal for distinguished service to humanity, presented annually by the American Social Hygiene Association.



Dr. Anton J. Carlson

Dr. Carlson is professor emeritus of physiology at the University of Chicago and an honorary vice-president of the American Social Hygiene Association, which with the VD Council of the City and County of Los Angeles is sponsoring the meeting.



Ernest Boyd MacNaughton

Mr. MacNaughton, president of Reed College, Portland (Ore.), is also president of the Oregonian Publishing Company, board chairman of the First National Bank of Portland, moderator of the American Unitarian Association, president and trustee of the Northwest Hospital Service (Blue Cross) and a vice-president of the American Social Hygiene Association.

At a morning session primarily for professional workers, Dr. Bruce Webster, associate professor of medicine at Cornell Medical School, and Dr. Thomas H. Sternberg, assistant clinical professor of medicine at UCLA's School of Medicine, will discuss changing aspects of VD treatment and control.

In the afternoon the Family Relations Council of Southern California will sponsor two panel discussions on new methods of helping young people prepare for personal happiness and maximum service to the nation. High school and college students will take part in one panel, with adults—parents, churchmen, school people and military officials—in the other.

"Our young people are the nation's most precious asset," Dr. Walter Clarke, executive director of the American Social Hygiene Association, declared in announcing the conference program. "Their experience in national service will contribute to their future happiness and usefulness as citizens and parents to the degree they are prepared for and protected in that service."

The American Social Hygiene Association will award four honorary life memberships this year at Social Hygiene Day observances in various cities. Those honored are Newell W. Edson, executive secretary of the Erie (Pa.) Social Hygiene Association; John Hall, of Freehold, N. J., formerly director of field service for the American Social Hygiene Association; Dr. Chauncey D. Leake, vice-president of the University of Texas' medical branch at Galveston; and Dr. Paul Zentay, president of the Missouri Social Hygiene Association, St. Louis.

Social Hygiene Day Slogan

For National Defense . . .

Foster Sound Family Life

Fight VD and Vice

BOOK NOTES

by Elizabeth B. McQuaid

Health Instruction Yearbook 1951, by Oliver E. Byrd, M.D. California, Stanford University Press, 1952. 236p. \$3.50.

For the health worker to be informed about current articles is imperative, for him to read them all is impossible.

Here, in this ninth edition of the yearbook, are 260 summarized articles from 108 different sources, culled from a total of 1500 articles read by Dr. Byrd. A bibliography, list of sources, author and subject indexes make it easy to find information about health problems, whether they concern syphilis, family health or adolescence.

An account of Philadelphia's VD case-finding campaign in 1949 and of syphilis among the Navajo Indians will be of interest to social hygienists.

Seksuellopplysning (Sexual Enlightenment), by Karl Evang, M.D. Oslo, Tiden Norsk Forlag, 1951. 664p.

This is an inclusive, interestingly but not sensationally rewritten edition of earlier publications by the author and his earlier collaborators which created much controversy before the war, but which, in the changed climate of Scandinavian attitudes, received a quiet and friendly public reaction in 1951.

It is widely read in Norway, especially by young people, and has had great influence also in Sweden.

The most significant addition is a chapter on morals and religion in which Evang, always frankly tendential, attacks the resistance and narrowness of the church as he sees it. He is for drastic changes, but vigorously insists upon ethical and social responsibilities in all human sex acts.

The book is excellently illustrated, and gives a mass of detail without becoming morbid. It is unfortunately without index or bibliography, but has a topical table of contents.

Prof. Thomas D. Eliot
Northwestern University
Evanston, Ill.
Dagfinn Sivertsen

The Menopause, by Lena Levine, M.D., and Beka Doherty. New York, Random House, 1952. 198p. \$2.75.

Written to dispel old superstitions and the consequent fears of women, this book stresses the naturalness of the menopause and the relatively few symptoms that can be ascribed to the menopause *per se*.

Chapters are *What Is the Menopause?* with a description of the reproductive organs; *What Is a Woman?*; *What Really Happens?* with a number of interesting case studies; *What Can Be Done?*; and *What of the Future?*

Many of the supposed signs of the menopause can be laid, the authors say, to the ambiguous demands our society makes on the middle-aged woman or to the fact that her family is undergoing change.

The optimism of the book is refreshing.

Attaining Manhood, by George W. Corner, M.D. Revised. New York, Harper & Brothers, 1938, 1952. 97p. \$1.50.

Attaining Womanhood, by George W. Corner, M.D. Revised. New York, Harper & Brothers, 1939, 1952. 112p. \$1.50.

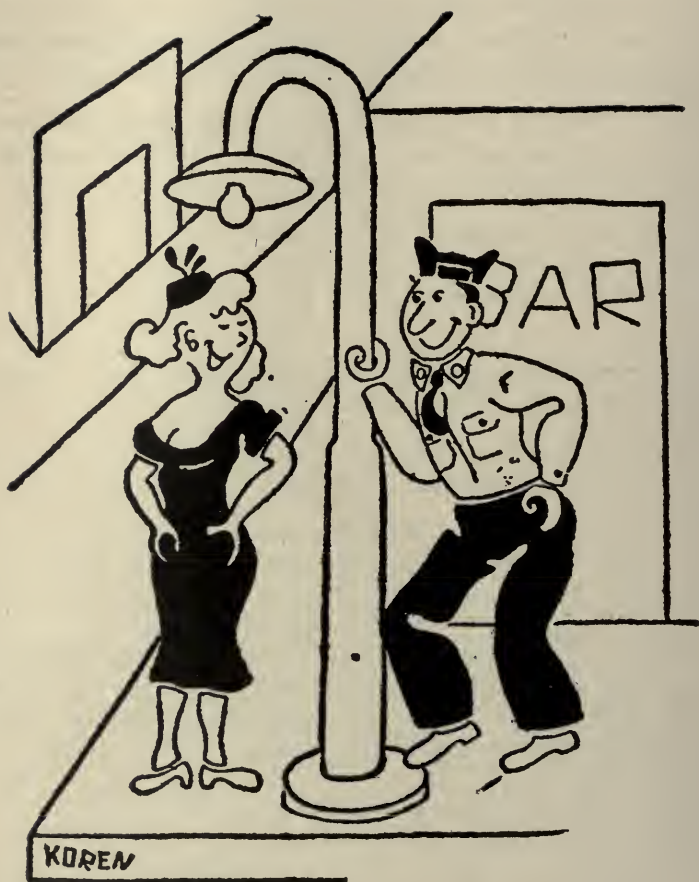
Written for the intelligent boy of high school age or the girl of 12 or older and her parents, these revisions incorporate new ideas about sex education and, like the older versions, use a friendly, non-technical approach.

They are amply and clearly illustrated and are written in two volumes to meet the special interests of each sex. There are chapters on the human reproductive system, sex attraction and mating, and sex conduct. Short bibliographies complete the books.

Fathers Are Parents, Too, by O. Spurgeon English, M.D., and Constance J. Foster. New York, G. P. Putnam's Sons, 1951. 304p. \$3.75.

Especially for fathers—but a gold mine for mothers, too—this book pleads that fathers take up their responsibilities within the home. “. . . It is from and through his father that the boy learns what men are like and what is expected of them.” Conversely, the girl can set up standards for her husband only if her father was her first “boy friend” in a satisfying way.

Some chapters are *Father Participates in Sex Education*, *Father and Adolescence* and *Your Children's Dating and Mating*. About sex instruction—“No arbitrary rules can be laid down for giving sex instruction because each child is different and the circumstances under which he is ready for it are varied.”



"If thou think'st I am too quickly won, I'll frown and be
perverse and say thee nay."

MAY 27 1952

journal of SOCIAL HYGIENE

vol. 38

may 1952

no. 5



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About our cover . . .

A scene from the movie, *Birthright*, documentary produced for the fight against congenital syphilis. Fourteenth of a series of Journal covers on family life . . . photograph by special permission of Communication Materials Center of Columbia University Press, copyright 1951.

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THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association. Subscription price: \$3.00 per year. Single copy: 35¢.

steady pressure on the prostitution racket

a police chief needs support

by Col. Forrest Braden

Police can whip prostitution as an organized racket.

Police cannot end prostitution nor can they end other law violations, but the prostitution racket can be reduced to a minimum. The size of this minimum depends on many factors:

- The character, ability and will of the head of the police.
- The authority and support given by the administration under which he operates.
- Available manpower, its training, character, understanding and acceptance of what is expected of it.
- Cooperation of and coordination with other law enforcement agencies, prosecutors and courts.

The foregoing sounds like an ideal setup. It is. But there are other important factors:

- An alert, informed, civic-minded citizenry, not apathetic, not inclined to accept vice as a necessary evil.
- Newspapers with the good of the community at heart, exerting a continuous effort to keep citizens informed of official acts and civic needs.
- Support by active civic organizations, service clubs, churches and an active, understanding board of health.

All of the above is a policeman's dream, a condition difficult to find. Each factor helps; the lack of any one makes the task a little more difficult and the lack of most of these factors makes the task trying and disheartening.

But with all of them missing except the authority and backing of the administration, police can accomplish much if so willed. Prostitutes, procurers, pimps, gamblers, hoodlums all wish to live in peace. A continuous pressure by police—and I mean continuous, not sporadic "drives,"—will discourage the most hardened until they'll leave for more peaceful fields where they are not unwelcome.

All offenses—big and small

A discussion of police and prostitution is meaningless if other vices and crime generally are not included. Any so-called "liberal" administration, winking at prostitution and gambling, finds its graph of murder, aggravated assault and robbery following the same upward curve as its vices. The same principle applies to minor offenses, from parking tickets up. "Fixing" traffic tickets, overlooking minor infractions by important people and politicians—and infractions not so minor—always become common knowledge and breed disrespect and contempt for law. Enforcement of all laws, consistently and impartially, is the most effective crime preventive yet devised.

Here are a few facts bearing on this theory: The FBI Uniform Crime Reports, initiated about 25 years ago by Director Hoover, provide a yardstick for measuring crime in cities in various population classes, enabling police to check on their progress or failure as compared with other cities in their class, their relative position with regard to similar communities and with the national and sectional averages.

On January 1, 1943, I went to Terre Haute, Ind., to become Superintendent of Police in the administration of Mayor Vern R. McMillan. We had been friends since World War I, when I had been his regimental commander and he had commanded one of our battalions. He was familiar with my work with the Louisville, Ky., police department in the early '20's and after his election in November, 1942, had asked me to come to Terre Haute and take over his number-one problem, the police force.

I accepted the task for the same reason I had accepted the Louisville appointment: both Mr. McMillan, a successful businessman, a popular, rough-and-ready sportsman, and Judge Huston Quin, mayor of Louisville, a quiet, earnest churchman who had resigned as a judge of Kentucky's highest court to become mayor, had one desire in common—each wished to be of the greatest possible service to his community, and, more vital



**Newspapers can be
a spur to action.**

than anything else, knowing my attitude toward law enforcement, each gave me full authority, with no strings attached, to enforce law impartially, regardless of politics of VIP.

I inject this personal angle because any police head will appreciate the advantages under which I worked. Frankly, we could not have accomplished any great proportion of our known results otherwise.

The west end

Back to our prostitution and crime facts: A survey of Terre Haute's brothel district, roughly three by four city blocks in area, known for 50 or more years as "the West End," had been made by outside authorities in the summer of 1942, about six months prior to our administration. This check listed 54 houses and the names of 104 prostitutes.

Our initial move included no raids. Word was sent to get out and stay out. Most of them left.

There remained several old-time madams who owned their homes and about whom we could do nothing, although they would attempt to resume operation if police vigilance was relaxed. A few persisted in trying to operate, encouraged chiefly by the fact that after hundreds of hours of police work costing hundreds of taxpayers' dollars in making an arrest supported by good evidence, they were slapped on the wrist with a \$10 fine. But under persistent pressure they finally moved out into the county, to operate unmolested.

Crime is expected to increase during wartime. In 1942, the first year of World War II and the year prior to our administration, there were 48 robberies (stick-ups) in the city, which was near the average for former years. In 1943, the first year of our administration, with the West End closed, there were 13 robberies.

Of the 48 robberies in 1942, 18 were in the West End. Of our 13 robberies in 1943, none was in the West End. Aggravated assaults dropped from 36 in 1942 to 14 in 1943. We had one murder against two in the previous year.

Terre Haute cuts down crime

The FBI Uniform Crime Reports deal chiefly with six crimes: three against the person (murder, robbery and aggravated assault) and three against property (burglary, larceny of \$50 value or more, and auto theft). During our administration the average for those six crimes in Indiana's six other "cities of the second class" (those with over 50,000 population) increased an average of 27% over the average of the same six cities in 1942, ranging from an increase of 12% for the lowest one to 65% for the highest one. The highest one had had a large influx of war

workers, it is true, but it is also true that prostitution and gambling flourished during that period. Against these increases, Terre Haute experienced an average *decrease* of 31% in the average of these six crimes as compared with 1942.



**“Little stuff”
doesn’t bother
some police.**



Crimes against the person are far more closely related to vice than are crimes against property. In 1942 Terre Haute’s crimes against the person were 30.8% above the national average in cities of 50,000 to 100,000. The following four years averaged 66% below the national average, this in the face of an increasing national average. The national average was compiled by the FBI from the Uniform Crime Reports of approximately 100 cities of the 50,000 to 100,000 class.

According to the National Safety Council, Terre Haute’s traffic deaths were 54% below the national average for cities in our class. What have traffic laws to do with prostitution?—as they are enforced as all laws should be enforced, impartially, and as they help set the pattern of law enforcement in a community. Here’s an incident very much in point:

While at Terre Haute I was appointed law enforcement consultant of the Chicago district (Wisconsin, Illinois and Indiana) by the Social Protection Division of the Federal Security Agency, which with ASHA, the U. S. Public Health Service and the Army and Navy was working on the VD problem during World War II. At a Peoria, Ill., conference—a follow-up meeting some months after the Peoria brothels were closed—one of my assignments was to address city and county officials, board of health, welfare workers, etc., at the City Hall. After my address a physician brought one of the visiting nurses up to repeat a story she had just told to him.

This was her story: While the drive was on to close the city brothels she had gone to the clinic to consult Doctor X about one of her cases. As he was engaged at the moment, she sat in the waiting-room next to two other women. From their conversation she realized they were prostitutes who had been ordered to report to the clinic, who knew they had to leave the city and who were speculating as to the best place to go.

They were discussing the possibilities of various cities when one asked the other, “What about Terre Haute? You used to work there.”

Number Two answered, "Nothing doing. I wrote old Mrs. B over there and she says to stay away, the town's too hot. And whadda ya think? She said when that new mayor gets a traffic ticket he goes right to the traffic office and pays his fine."

Number One, "Oh, my Gawd!"

Terre Haute was out. A traffic ticket vs. VD.

John Edgar Hoover

At Louisville our refusal to let politicians interfere with impartial enforcement of all laws, including the use of the "quarantine" against prostitution, had a decided effect on "major" crimes. This was just when a young law clerk in the Justice Department, John Edgar Hoover, was appointed director of the FBI and before the development of his present thorough system of Uniform Crime Reports. But the effect was so evident that it drew the attention of observant police in other cities. One illustrating incident:

In the fall of our fourth year a detective sergeant and the comptroller of a city of comparable size, down to attend the fall races, visited me at my office before going out to Churchill Downs. In discussing the then-current wave of bank hold-ups around the country, the comptroller asked how many we had had. I told him, one during our first year, three of the robbers in prison and the identity of the fourth known.

He asked the sergeant, "How many have we had, Rugey?" The sergeant said they had six or seven in the same period.

Enforcement—not luck

The comptroller said, "Say, these folks are lucky, aren't they?" The sergeant grinned, shook his head and said it was not luck and suggested that he ask about personal stick-ups. I checked and found we had had seventy-odd that year.

The comptroller turned to his detective friend and said, "Listen, Rugey, we have that many at home every night. Why do you say they're not lucky here?"

The sergeant then spoke more seriously. "OK, Joe, now that you've asked me, here it is. I've been here often, on court cases and after prisoners, and I know how this force works. Down here they try to enforce all laws and they don't care how much political or financial weight the customer carries. They even work hard at this — prohibition law. We've got a lot of good-time girls up home who were run out of Louisville and with them are a lot of bums who left with them.

"Now take us up home. We're big shots in police work. We only work on big stuff—murders, bank robberies, safe-cracking and so forth.

We don't bother with little stuff—gambling, prostitution, bootlegging. We're too busy with important things. Looking after little moral matters is the job of the churches, schools and the 'do-gooders.'

"Our big boss claims a liberal policy means prosperity for the city. Liberal means wide-open to the good-time boys and the rats have swarmed in on us. Ask any of them about Louisville and they'll tell you it's too hot down here."

There was more conversation between them there in my office, but my most vivid recollection is of the thought that kept racing through my mind: I knew their mayor, a most likable but erratic character, whose comptroller must have had a difficult job keeping the city's financial ship on an even keel. But if he, a member of the mayor's cabinet, had not been aware of the harm done to the city and its reputation by the mayor's "liberal" policies until his detective friend's plain-speaking opened his eyes, what about the residents of their city? Were they living in ignorance also? Had their civic education been neglected also?

Alertness or apathy

An alert, informed, understanding and active citizenry is the most vital need of our day if we desire good government, from the smallest town to the national level. Apathy, smugness, aloofness, acceptance of vice as a necessary evil all lead to moral flabbiness, which persists until conditions smell to high heaven—when the public may then demand action. I think it was Herbert Spencer who wrote, in effect, that a free and self-governing people get the kind of government they deserve.

A police department, if it has the confidence and active support of the citizens, can make any community a better and safer place in which to live and labor. Much depends on newspapers, civic organizations, churches and leading citizens if the public is to be kept alert and informed, but a police chief can do much by appearing before various groups and speaking frankly, laying his problems before them, showing how they as citizens can help.

He will be astonished by two things: their misconceptions, illusions and abject ignorance on the one hand and their readiness to help and support his efforts when their eyes are opened and they acquire understanding. The response will be a most heartwarming experience when they understand the problems. To illustrate:

Policemen are people, too

Accepting an invitation to address a group representing a men's organization of several Lutheran churches of Louisville, I had talked quite a while without seeing any evidence of interest on their faces and I changed from routine explanation of police work to try and wake them

up. I asked for a showing of hands by those who had ever noticed that a new face had shown up on the police beat past their home, either on foot or in a car. Nearly every hand went up. I then asked how many knew the names of the men on their beat. Only one hand showed.

I told them they were not doing their part as good citizens, that the man down at the corner poolroom, a suspected bootlegger, didn't just notice a new policeman's face. When the new face appeared the man on the corner was right there to greet the new policeman in a friendly manner, asking him all about himself and his family, inviting him to use the phone at the poolroom when he needed it (this before police radio) and to drop in when the weather was bad, etc.

With this occurring only with people who looked as if they might be the wrong kind of citizens to have as friends, what would be the reaction of the new policeman? Policemen are people—most with families—who like to have the right kind of friends. I thought the good people should help us by giving the wrong kind of people some competition, showing they also wished to be friends of the police.

When I brought my talk to an end most of them filed by and shook my hand. A few said, "Thank you." I left feeling that I had not accomplished much with that stolid group. A day or two afterward, one of our new men, just out of police school and assigned with an older man to a residential section, told me a man had stepped out from his front yard, stopped their car, told them his name, asked their names, inquired about their families and where they lived, told them about his family. Then, when he seemed to have run out of talk, they asked him what they could do for him. He had said, "Nothing, thank you. I just wanted to get acquainted with you men and let you know our family appreciates the work you are doing."

It made us feel good

My new man then told me two of the men on another beat had reported that two men had done a similar thing with them the same day. He added, "After we talked about it we all decided it was about the nicest thing that could happen, stopping us to tell us they liked us and what we are doing. It made us feel mighty good."

A few days later a committee of five from that Lutheran group filed into my office, and their spokesman briefly reported that all their members now knew the names of "our policemen" and had met them. This solid, earnest group had promptly done the only specific thing I had suggested in all my talk at their meeting.

Since then I have often speculated on what might be accomplished if a newspaper assigned a first-class reporter to the police beat—not to hunt for sensational angles in police court cases or sob-sister stories behind



**Spanish-American War veteran.
Regimental Commander in World War I.
One-time Chief of Police, Louisville.
Chief of Police, Terre Haute (ret.).
Fearless champion of law enforcement.
Col. Forrest Braden.**

routine court action—but, working with the heads of police divisions, to develop and publicize every possible idea which might bring the citizen and the police into closer harmony through a clearer understanding of the viewpoint, problems and responsibilities of each other.

The American Social Hygiene Association's war against VD has educated the public to a remarkable degree during the past few decades, particularly regarding social and family welfare as related to VD. But years of misrepresentation and propaganda by the beneficiaries of the prostitution racket have established misconceptions that still persist in the public mind regarding the problem from the police viewpoint.

Whose daughter?

A police head can do much to correct this in his contact with the public. Once when addressing a service club I talked but a few minutes and then suggested they ask questions, so that I might know what interested them. One promptly asked, "Don't you think real, thorough regulation of prostitution would in the end be best?" I said, "No." He promptly asked, "Why not?"

I explained the VD angle, the cruel joke of the physician's "certificate," the American Medical Association's opinion that a physician who "certified" a prostitute as non-infectious was either incompetent or dishonest. I told them of records proving the tie-up between prostitution and other crimes, pictured the type of hangers-on, the scum who felt welcome in any city where brothels were open, and wound up with the reasonable proposition that "thorough" regulation should cover every angle of the business from beginning to end. I pointed out that a brothel district could not operate with worn, faded women; fresh, young and attractive women would have to be recruited and of course the recruitment should be regulated.

With this premise established, I asked him, "Who would you suggest to regulate recruitment? Whose daughters do you think should be recruited?"

My questioner promptly held up both hands and called, "Hey, wait a minute. You're springing angles I never thought about. I withdraw my question."

A police chief can create opportunities to inform the public and to correct opinions which have been accepted without study or investigation—ideas which usually are the fruit of propaganda by interested parties. He need not be an orator, a public speaker. All he needs is to be articulate, to possess facts that prove his points, to be sincere and to have the courage of his convictions.

The good old days

A committee of businessmen were in my office where we had been discussing a proposed new traffic rule. Here was an opportunity: They were relaxed, apparently in no hurry to leave and, more important, among them was one who, a friend had reported, favored the old "regulation" idea for prostitution. I pointed through a window in the direction of the old red-light district and asked if they had noticed the physical changes—16 old houses torn down, commission houses erected, warehouses, a trucking freight house built, a trucking company headquarters.

After several had commented favorably on the change, the man I had in mind said, "Look, Chief, maybe that old idea of prostitution being a necessary evil is wrong, but I've just been thinking of those old days when I first came to town. As I remember, those were good old days. Maybe some things are morally wrong, but there didn't seem to be as much trouble as now. Everything seemed all right and everybody seemed happy."

"That reminds me," I answered. "I was examining an old annual police report before you men came in. It caused me to check our record on suicides for last year. There were two women who attempted suicide, one because of ill health and one because of family trouble. Now take a look at this booklet, a report of over 35 years ago, just about the time you came here."

My daughter?
Oh, no.



He and the others began examining the book. "Look, Jim!" he cried to one of the older men. "You remember Chief Blank? Look how he was rarin' back when that picture was taken. Remember how he used to strut up and down the center of town in his uniform? He was always bragging of how quiet and orderly he held 'em down in the old West End."

I called their attention to a chronological list of the year's serious accidents, murders, malicious assaults, suicides or attempted suicide. They were reading various entries when he asked, "Chief, did you mark these attempted suicides?" I replied, "Yes, and if you examine that section of the report you'll find 29 attempted suicides marked, all but one of them girls of the West End. Nine died and 19 recovered, all within one year of those good old days when everybody was happy. Twenty-eight women so happy they tried to die."

While they sat in shocked silence over that black record I fired another shot. "In addition to setting records for suicides, the West End holds another. This county, in proportion to population, has furnished far more VD-insane patients for the Southern Hospital for the Insane than any other community."

Those six men left my office expressing wholehearted support of our anti-vice program.

Continuity of good service

If a police chief has free rein to direct police activities, the results are then entirely up to his ability, fidelity and courage. If he is only a political appointee for a limited period under the wrong kind of administration, he's helpless. Merit system and tenure laws are the most important factors bearing on police efficiency and these vary in the different states from good to poor to none. With the best qualified man selected to head the department, aided by good state laws governing police, recruitment, training, merit system and tenure, then the citizen gets a real break for his tax dollar—continuity of good service.

Pittsfield, Mass., is an example of the right combination. When John L. Sullivan retired as chief a few years ago after 34 years' service, every civic organization joined in a farewell party. Their admiration and respect for John Sullivan was ably expressed in an open letter by District Judge Charles L. Hibbard: ". . . Your conscience and sense of duty have been your guides. You have been fully aware of the fact that if vice becomes established in a community it exhales a poison which numbs the personal and public conscience and spreads its roots ever deeper and wider. Once established, it is difficult of eradication, and so you have consistently and even in the face of determined opposition crushed it in its beginnings. . . ."

Intrigued by the judge's "against determined opposition," I investigated and learned that many years ago when a new administration had attempted to "open up" the city, the police—under Chief Sullivan—would not permit it. As an old resident expressed it, "John Sullivan just whipped them into continuing decent government in Pittsfield."

This long tenure could not occur in my native state of Indiana nor in many other states, where practically every change in city administrations means a new police chief—usually selected for political reasons—and where any chief who attempted to enforce laws contrary to the wishes of the mayor would be ousted immediately. In such states, really efficient police departments can never be developed. Recruitment and promotions for political reasons and change of chiefs every four years make such a goal impossible.

Best-policed city

John L. Sullivan's character and accomplishments were recognized far beyond Pittsfield's limits. For many years the International Association of Chiefs of Police continued to re-elect him treasurer until his retirement. In John Gunther's book, "Inside U.S.A.," the author devoted one paragraph to listing the most beautiful, ugliest, cleanest, dirtiest, etc. cities. His "best-policed" city was—Pittsfield, Mass.

Among the larger cities, the over-500,000 class, Milwaukee stands out. It is another example of the results of impartial enforcement of all laws over a long period. The National Safety Council's records show Milwaukee at the top of the list of all large cities in accident prevention. Prostitutes never give Milwaukee any consideration as a place to "work." Even back in the rampant vice days of the 1920's, when Chicago gangsters were closely tied in with cities as distant as Minneapolis and Kansas City, the name of Milwaukee—a neighboring city only 80 miles from Chicago—seldom appeared in front-page crime news. It was given a wide berth by Chicago gangsters.

In the final analysis, good government—local, state and national—lies in the hands of the citizens. An alert, informed citizenry, patriotically exercising its elector rights, can have the kind of government it desires. Let us not only hope but work for it.

**Citizens can have
the kind of
government
they want.**



Good Laws . . . Good Tools

Injunctions and abatements versus Houses of prostitution

by Bascom Johnson

The maintenance or operation of a house of prostitution has long been a criminal offense in 46 states and the District of Columbia.

Even in Arizona and Nevada it has been a misdemeanor to operate such a house near a school or church or on a principal business street. The legislatures of both states have empowered common councils to suppress what are known in Arizona as "disorderly houses" and in Nevada as "houses of ill fame." In addition, Nevada councils have the authority to regulate the houses.

Houses of prostitution have long been held to be public nuisances under the common law which we inherited from England. Courts of equity have had the power to prevent their continued operation and to close them by abatement orders.

However, a private citizen couldn't initiate action against a house in a court of equity unless he could show that he suffered special damages different from those he suffered in common with the public. Usually he had to prove that the house of prostitution was located so near his property as to injure its value.

For this and other reasons, houses of prostitution have usually been located in deteriorated or rundown neighborhoods where residential or business properties couldn't be much further deteriorated by the proximity of brothels. Businessmen were often glad the brothels were there because of the large profits they made from sales to exploiters, prostitutes and their many customers.

They Continued to Operate

As a consequence, in spite of criminal laws and the powers of equity courts, houses of prostitution continued for years to operate openly. Many were in segregated districts, hampered scarcely at all by monthly fines levied by the police and courts—fines which, in effect, were license fees and which gave the city a share in the proceeds of prostitution. Likewise, the city shared responsibility for the traffic in women and girls that always accompanied open operation of brothels, especially when grouped in a red-light district.

There is little doubt that many of our public officials thought they were representing public opinion in their tolerant attitude toward houses

of prostitution. Otherwise, they would have done a much better job of preventing and repressing brothels with the powers and laws they possessed than they did do.

Iowa Led the List

In 1909 Iowa passed the first complete injunction and abatement law. It was an eye-opener for it proved to Iowa's officials that the people of the state were not satisfied with official inaction against openly operated houses of prostitution and were determined to take a hand, if necessary, in their elimination.

(Maine in 1891 and Texas in 1907 had already passed laws which contained this principle of citizen participation, but their laws lacked some of the important provisions of the Iowa law.)

Iowa's injunction and abatement law declared brothels and their contents to be public nuisances. It gave to any citizen of any Iowa county and to any society, association or body incorporated under Iowa law, as well as to any county attorney, the right to apply to a judge in a court of equity for an injunction restraining the owner, operator and agent of such a nuisance from further permitting or maintaining its operation.

Three days' notice of the application had to be given the owner and operator of the nuisance. If one or the other requested a continuance, a temporary injunction was to be granted as a matter of course.

If a judge was satisfied from the evidence at a hearing that the nuisance existed, he granted a temporary injunction, without bond, pending trial. Any injunction, temporary or permanent, was binding on the defendants throughout the judicial district.

If a temporary injunction was applied for, the court, on application of the plaintiff, might issue an order restraining the defendants and all



The city shared responsibility for the open operation of brothels.



*Poor neighborhoods
attract brothels.*

others from removing or in any way interfering with the furniture, fixtures, musical instruments and movable property used in conducting the nuisance until the decision of the court.

The trial had to be held at the first term of court and the general reputation of the house was made admissible to prove the existence of the nuisance. The court was given power to expedite cases to trial and to discourage frivolous suits.

If satisfied of the existence of the nuisance at the trial, or if its existence was established in criminal proceedings, the court was to issue a permanent injunction restraining all parties from continuing the nuisance. The court was also to issue an abatement order removing and selling the personal property used in the house and closing the premises for any purpose for one year—unless sooner released by the court upon payment by the owner of certain costs and the giving of bond by the owner for good behavior on his property during that period.

The proceeds from the sale of the personal property were made available to pay for its removal and sale and for closing the premises and keeping them closed.

When the court issued a permanent injunction, a tax of \$300 was assessed against the building and grounds, against the persons maintaining the nuisance and against the owner and agent of the premises. The tax remained a lien upon the property until fully paid.

Violation of any court order was made contempt subject to a fine of from \$200 to \$1000 or to imprisonment from three to six months or to both.

Trials were summary and without juries.

Differences in Laws

Since 1909, 40 additional states (all except Vermont, Oklahoma, Nevada, New Jersey and Pennsylvania) and the District of Columbia have passed injunction and abatement laws which contain the principle of citizen participation. In New Jersey and Pennsylvania law enforcement officials may secure abatement orders from the courts (in New Jersey, from the criminal courts) and in Pennsylvania they may also obtain injunctions against owners and operators.

Many of these later laws differ from the Iowa law. Some of the differences are fundamental but most of them relate to minor details of procedure.

A basic difference from the Iowa law exists in the laws of nine states (Arizona, California, Colorado, Delaware, Minnesota, Montana, New Hampshire, Oregon and Texas), which provide that wherever houses of prostitution exist the law enforcement officials *must* or *shall* initiate actions to enjoin and abate them rather than *may* do so, as provided in the Iowa law.

The laws of seven states (Maryland, Missouri, New Mexico, Rhode Island, South Carolina, Texas and Virginia) give the power to initiate injunction suits to any citizen of the state rather than to only those citizens of the county in which the nuisance exists, as provided in the Iowa law.

The state attorney general as well as the district or county attorneys have the power to initiate injunction and abatement actions in 21 states and the District of Columbia. These are Alabama, Delaware, Georgia, Kansas, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, North Dakota, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, West Virginia and Virginia.

If the existence of the house of prostitution is established in a criminal proceeding, the laws of 19 states require that an order of abatement *shall* be entered as a part of the judgment in the case, whereas in Iowa and Washington this *may* be done and only in part. These 19 states

are Indiana, Iowa, Kentucky, Minnesota, Mississippi, Nebraska, New Hampshire, North Carolina, North Dakota, New Mexico, New York, Ohio, South Carolina, Tennessee, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

Like Iowa, 13 states provide in their laws that personal property may not be removed from the nuisance premises pending trial. They are Indiana, Louisiana, Massachusetts, Minnesota, Michigan, Mississippi, New Hampshire, New York, North Dakota, Ohio, Rhode Island, Tennessee, West Virginia. The other states lack this provision.

Common Law

As I've said, houses of prostitution are and have long been public nuisances at common law in this country, and the jurisdiction of equity courts to abate public nuisances has also been well established. Doubtlessly for this reason, there have been few attacks in the courts on injunction and abatement laws, and their constitutionality has been generally upheld when attacked.

One exception is the provision relating to the \$300 tax—which was in the Iowa law and also in the laws of a number of other states—following the issuance of a permanent injunction. The higher courts of New York and Nebraska have held this provision unconstitutional, and doubt concerning its validity has probably influenced most of the states to omit it from their laws.

The Barbary Coast

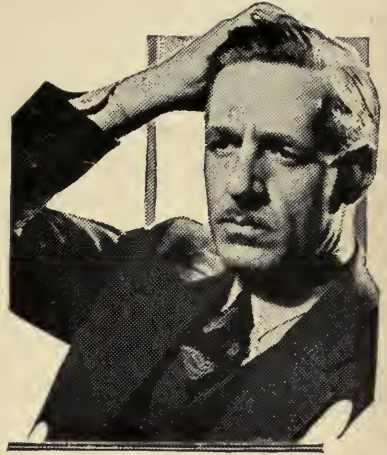
When first passed, injunction and abatement laws were used by citizens or private associations with notable results, particularly in Iowa, Minnesota, Nebraska, Oregon, California and the District of Columbia.

San Francisco's red-light district, long notorious, resisted for years the fulminations of press and pulpit. Even after the state legislature passed the injunction and abatement law in 1913 and made it the mandatory duty of the district attorney of any city or county to start proceedings to abate open brothels, two years went by without official action against the Barbary Coast.

Fortunately, the California law provided that any citizen of the county might initiate action "in his own name" to abate a nuisance.

In 1915 San Francisco's private social hygiene organization, the California Law Enforcement League, decided after many vain efforts to stimulate official action to bring cases in the name of a private citizen. Eleven times during the following seven months they were completely successful—and 11 Barbary Coast houses were closed by court order under the injunction and abatement law. Another house closed volun-

*He doesn't like
that brothel.
Why doesn't
he take action?*



tarily. One case (Chown vs. Alexandra, 35 Cal. App. 194) was appealed and upheld in the higher court.

The city officials thereupon decided to make a virtue of necessity and closed the remaining 90 houses in the red-light district by executive action. The Barbary Coast never reopened.

Another private organization—the Morals Efficiency Committee of Los Angeles—helped to accomplish a similar clean-up through the use, or threatened use, of the injunction and abatement law. Doubtlessly because prostitution had never been so solidly entrenched in Los Angeles as in San Francisco, members of the committee were able to obtain the complete cooperation of the police department and district attorney after they had filed their first case with the district attorney in February of 1915. During the following nine months 203 cases were investigated and abated.

The police and Morals Efficiency Committee handled 132 of the 203 without publicity. The district attorney abated, without suit, 50 cases on information furnished him by the police. Twenty cases were tried in court by the district attorney and perpetual injunctions obtained against the landlords, proprietors and inmates . . . the furniture was sold by the sheriff. In only one case was it necessary to try a landlord for contempt and to close his property for one year by court order.

Immediately after the passage of Nebraska's injunction and abatement law the Omaha police and county attorney, acting together in a combination of legal and executive action, closed Omaha's red-light district. Combined operations succeeded also in Portland, Ore., Washington, D. C., and Duluth.

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World War I Major.
One-time director of ASHA's
legal and protective services.
Bascom Johnson*



Effect of Law on Public Officials

The mere existence on the statute books of the injunction and abatement law has influenced unwilling or indifferent public officials to close red-light districts either by using the law or by executive action. Often the threat of independent citizen action forced reluctant officials to act. Officials could point out to owners and operators of brothels that unless they themselves closed their houses, citizens could easily and quickly obtain temporary injunctions. Violation meant contempt of court and severe penalties . . . followed by permanent injunctions and abatement orders with additional and more severe penalties.

Under criminal laws, delays, evasions, personnel changes and other time-killing devices often made the closing of red-light districts difficult to accomplish, at least quickly. When there was complete reliance on the use of criminal laws, numerous raids, arrests, trials and convictions—sometimes lasting over a period of several years—were often necessary before the prostitution business became too unprofitable to continue.

Since those early days from 1909 to 1920 few private citizens or associations have found it necessary to initiate action against houses of prostitution. Usually their officials respond promptly and satisfactorily to aroused public opinion.

Today there's only one red-light district in the United States . . . in Galveston.

Such open houses of prostitution as exist today are often located outside the city limits. Out in the country they are less noticeable, and obnoxious to fewer residents. This is particularly true in California, Texas, Florida, Georgia, Nevada, Oregon and Washington.

Another reason for greater laxity in rural areas may be that county sheriffs, unlike city police, are elected officials and are therefore harder to convince in the absence of overwhelming public opinion against such

places. And public opinion, in turn, is much harder to organize among widely scattered rural families than in closely packed cities.

The Citizen's Job

While Nevada has no injunction and abatement law, California, Texas and Oregon do have such laws. They are three of the nine states whose laws make it mandatory for county attorneys to initiate action against open brothels.

It would appear feasible for any citizen of a California, Texas or Oregon county where a brothel is now operating to call the attention of his county attorney to the law *requiring* his action to abate the house of prostitution. Failing official action, there remain the possibility and probability of citizen intervention.



"Mother, did you know you're a member of the lost generation?"



Sex Attitudes and Venereology in New York City one hundred years ago

by Joseph Hirsh

This year The Mount Sinai Hospital of New York is celebrating its centenary,* thus taking its place alongside of a handful of other hospitals in the United States which have seen continuous service for 100 years or more.

Originally incorporated as the Jews' Hospital in 1852, Mount Sinai quickly adopted the nonsectarian policy it has maintained ever since, and in 1866 changed its name to its present one.

The Mount Sinai Hospital passed through its adolescence in a period of history on the political front characterized by expansionism, empire-building and industrialism; on the social front characterized by Victorianism; and on the medical front characterized by the growth of science and technology. These three milieus had a profound influence on the growth of the hospital and, so far as venereology is concerned, on the attitudes expressed by members of the boards of directors as well as the doctors towards patients with syphilis and gonorrhea.

* See Hirsh, J. and Doherty, B. *The First Hundred Years of The Mount Sinai Hospital of New York: 1852-1952*. New York, Random House, 1952.

sipation was particularly fond of women. At the time he first com-
 plained he was in California. He had severe pains in back & limbs which were
 supposed to be of a rheumatic character. He neglected himself & eventually
 in every respect as usual. In spite of his neglect the pain subsided & he
 thought the disease gone. But some time afterwards he experienced some
 difficulty in walking: he found himself stumbling easily. On attempting to use
 his limbs, he sometimes could not carry his intention into effect, the muscles
 not exactly obeying his will. This difficulty increased until he walked
 very unsteadily indeed even with the aid of a stick. He complains again
 of pain in the back & a very uncomfortable sensation of tiredness as
 across the needles after moving for a little while. In walking he drops his
 limbs, in standing he must put his feet asunder otherwise the centre
 of gravity is apt to go too much on one side. He is generally, & with
 exception of sleeplessness at night. Otherwise feels hearty enough. Appetite good.
 (March 22). Feels much improved in general condition as well as com-
 mand over his limbs. His treatment & regimen since admission has been
 directed towards strengthening his general system & increasing the nervous sys-
 tem. Electricity has been applied to his inferior extremities, counter-irritation
 to the spine besides camphorated volatile liniment to painful rheumatically

An old case record

This point of view was reflected also in the hospital's attitude towards
 such patients evidenced in the following resolutions adopted by the board
 of directors.

In March, 1860, the board of directors "Resolved that single women
 suffering with syphilitic diseases are . . . not proper subjects for the
 hospital. . . ." Taking a double-standard view, typical of the times, and
 characteristically doubtful of the integrity of such patients, the board
 ruled in this same resolution that "no male so suffering [shall be
 admitted] without paying one month in advance". In June the board
 relaxed somewhat and amended the resolution to read, "that women
 suffering with syphilitic diseases should not be admitted unless they
 bring testimony of a previous good moral character". The resolution
 on men stood.

Mount Sinai's early history is replete with other evidences of Victori-
 anism. The *Case Book* of the first four years of operation (1855-1858)
 is revelatory not only of such attitudes but of practices in treatment that
 are now happily part of history.

In reading the following extracts from histories taken from the early
Case Book, the reader is reminded that *treponema pallida* and *gonococcus*
neisseriae were not discovered until 1905 and 1879, respectively.

The following case, in a sense, typifies the treatment of lymphadenophthy
 and buboes by surgical intervention. It also indicates the satisfaction

that practitioners had with the disappearance of such overt symptoms as buboes and syphilitic ulcers and their belief that the disease was cured when these symptoms had gone.

Case 49 Syphilis primary

"... age 22 — native of Poland. Suffering from Bubo and Syphilitic ulcers — the latter commencing 2 weeks ago — and the former one week. Treatment: Ulcers were cauterized and a lotion of black wash applied. Bubo was opened and considerable pus discharged. A poultice was applied. Constitutional treatment — Hydrarg Bichlorid with Tr. Cinchon. Comp. This treatment was continued for one week at the end of which time the chancre and the general health improved — but the bubo still remained and continued to suppurate. Bubo again incised and poultices continued. It continued to discharge a small quantity of pus and gradually to diminish in size until . . . when the patient left at his own request."

The following case suggests the reasons why patients suffering venereal disease were considered poor management risks within the hospital. It also indicates the stereotype association of drinking and sexual excesses.

Case 108 Syphilitic Rupia with dementia from drink

"... age 45 years. Single, native of London . . . Suffers from Rupia Syphilitica over the whole body and accompanied by dementia from drink and venereal excess.

He was from the first exceedingly troublesome — and had to be discharged for disorderly conduct towards the nurse on. . . ."

In the following case we again see concentration in treatment on the dermatologic aspects. The belief in cure with the disappearance of these symptoms is again present.

Case 123 Scrofulous ulcers with Secondary Syphilis and Spermatorrhoea

"... age 25, married. Has three children — one now suffering from transmitted constitutional syphilis. Had syphilis several times during last eight years, and now suffers from Secondary Syphilis, complicated with extensive scrofulous ulcerations of left arm —, and slight on left leg — with Spermatorrhoea and necessarily very depraved general health. Ordered

Potass. Iodid
Syr Sarsap Comp
Tinct Cinchon

. . . dress the scrofulous ulcers with Nitric Acid Lotion.

The Iodid disagreeing very much with the patient — causing swollen eyes and puffy lips,—I changed it for Bichlorid Hydrarg
Tinct Cinchon
Syr Sarsap Comp

[Five weeks later the progress note read] Doing remarkably well — ulcers healing kindly. The same treatment was continued until . . . when he was discharged much improved."

Stereotype association of sexual and drinking excesses is evidenced in the following case. The whole moral tone of the case report and the attitude towards sexual practices is characteristic of the Victorian period.

Case 128 Nervousness

". . . age 22 . . . He states that 12 months since he contracted gonorrhoea, which was soon suppressed by injections of Zinci. Sulph, and with this exception he has always been exempt from disease. Upon close examination it was ascertained that he had been long addicted to over-indulgence in drink, and masturbation. He complains of spermatorrhoea and slight difficulty of micturition. Appetite good, bowels regular, and pulse full though somewhat irritable. Ordered:

Ferri. Sulph. gr xvi
Ext. Nuces Vomicae gr iv
Ext. Gentian.

[One week later the progress note reads] as yet had no emissions — urinates more freely. Discharged improved with advice to abandon his evil habits."

The following case, admitted to the hospital 20 years after Robert Remak in Germany described the clinical symptoms of *locomotor ataxia*, is interesting because of its classical description of the disease. Its nomenclature was yet to be generally adopted in the United States.

The whole moral tone of the case write-up, like so many others, is characteristic of the period in which social excesses of all kinds were frowned upon.

Case 268 Paralysis. partial Extrem. infer.

". . . native of Bangowitz, Duchy of Posen, age 38 years. Married. . . . The history that he can give is somewhat unsatisfactory but the following seem to be the main facts. It appears he for a long time has been a man of irregular habits. He indulged in many carousals,

travelled round a good deal, exposed himself to wet and cold in his dissipations and was particularly fond of women. At the time he first complained he was in California. He had severe pains in back and limbs which were supposed to be of a rheumatic character. He neglected himself and went on in every respect as usual. In spite of this neglect the pain subsided and he thought the disease gone. But some time afterwards he experienced some difficulty in walking: he found himself stumbling easily: On attempting to use his limbs, he sometimes could not carry his intention into effect, the muscles not exactly obeying his will. This difficulty increased until he walked very unsteadily indeed even with the aid of a stick. He complains again of pain in the back and a very uncomfortable sensation of tiredness across the ancles after moving for a little while. In walking he drags his limbs, in standing he must put his feet asunder otherwise the centre of gravity is apt to go too much on one side. Bowels generally costive and, Sleeplessness at night. Otherwise feels hearty enough Appetite good. . . . Feels much improved in general condition as well as command over his limbs. His treatment and regimen since admission has been directed towards strengthening his general system and increasing the nervous supply. Electricity has been supplied to his inferior extremities, counterirritation to the spine besides camphorated volatile liniment to painful rheumatically parts. His bowels are regulated whenever needed, . . . He went on somewhat improving and after a few weeks could walk about very well with the aid of a cane and all his trouble seemed to have left him except that he felt after some exertion a sensation of weakness and tiredness over the ankle joints."

The following case again illustrates the importance placed upon surgical intervention in the treatment of gonorrheal sequelae in the male.

Case 201 Orchitis with suppuration

"Native of Prussia aged 35 single was admitted to Hospital. . . . He states that he contracted gonorrhoea for the first time four weeks since, and which was followed by pain and tenderness in the left testicle, which increased accompanied with redness for several days, and was then apparently subsiding, when he took a ride for several miles in a country farm wagon. Having jarred and irritated the parts very much, on the next day all of the symptoms were materially aggravated and have so continued until the present date. The left portion of the scrotum is considerably swelled, and presents a shining redness, attended with severe pain. . . .

[In addition to internal medication there was ordered the] application of three leeches to the perinaeum.

[Three weeks after admission with] No apparent change in appearance and Considerable fluid . . . within the vaginal tunic, and scrotum still excoriated . . . A crucial incision was made into the cavity and plugged with lint.

[Six months later the wound in the scrotum had still not healed completely, but] Since there was such general improvement in the patient's condition, he was discharged."

The following case is noteworthy for the moral tone of the write-up, the commentary on quackery in the treatment of venereal diseases — a problem just beginning to be resolved in our time — and for the description on methods of treatment.

Case 304 Primar. Syphil. with Mecurialism

". . . native of Wiesloch near Heidelberg, Baden, age 24 years, Single, by occupation a Carman . . . About the middle of December last he contracted Gonorrhoea, in spite of which he continued to have impure connection nearly every night. Towards the beginning of February while gonorrhoeal discharge still continued he also observed a chancre on the collum behind the corona. He then doctored regularly and irregularly, consulting chiefly quacks, however, until three weeks before admission he fell into the hands of an Apothecary who mercurialised him so intensely that he entered the hospital in a truly piteous and miserable condition. Gonorrhoeal discharge had ceased two weeks ago. His penis is affected with at present two nasty phagedenic chancres and the sunken cicatrices of two others. One of the ulcers is on the glans the other on the collum involving the corona. The edges of both are ragged and undermined, the surface foul, dirty yellowish red of irregular circular shape. . . . His constitution seems completely prostrated and broken down. . . . Countenance troubled, pallid and contracted, complains of headache and intolerable buzzing and pain in both ears and whole head. Appetite almost wanting because deglutition very painful as well as mastication. The skin especially on his arms is of an unhealthy coppery appearance. Patient is emaciated and irritable, desponding and yet impatient. Examination of ears, nose and throat showed no distinct secondary symptoms but rather mecurial. The treatment under which he was placed comprised besides general attentions to health by pure air, temperature, etc. nutritious and most easily digested diet with beef tea, porter, etc. especially everything wanting no mastication. [Local treatment of ulcers was with tanic acid and other prescriptions common to the day.]

[Ten weeks later we find that] All the Secretions now are normal. Treatment and generous diet continued until patient was discharged as Cured."

The following case is characteristic of the general tone of venereal disease history write-ups as well as management.

Case 353 Gonorrhoea

". . . native of Steinsloff, Galitzia, Austrian Poland, age 37 years. Married, Pedlar, admitted . . . with Gonorrhoea. He stated he was married but has not for a year and a half lived with his wife having accidentally met her while she thought him absent from the city, in a house of ill fame. He contracted the gonorrhoea under which he labors at present, 2 months ago. He put himself under treatment, regular and irregular; and the symptoms gradually subsided, the discharge diminished and became mucous, without pain, redness, round orifice, etc., but this gleet was rekindled into inflammatory gonorrhoea by continued imprudencies. Patient is of full habit, dirty white tongue, Bowels irregular, etc.

[Twenty days later, after local and constitutional treatment, the patient] Left hospital at own request, though warned. At present Cured."

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Executive Secretary, Medical Advisory Board,
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Joseph Hirsh



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Capsule plan for citizen- military morale

Presented at ASHA's annual business meeting

by Colonel Lindsay P. Caywood (MPC)

I consider it a high honor to discuss a matter of mutual interest and grave importance to the well-being and national defense of our nation—the youth of the United States who presently constitute a major portion of our Armed Forces and those who will be drafted in the future.

Let's take a minute and briefly touch on some statistics regarding our Armed Forces. I'm sure they will drive home the real need for practical, constructive and far-sighted planning closely coordinated between representatives of the civilian population and representatives of the Armed Forces.

Did you know . . . ?

★ The present size of the Armed Forces totals approximately 3,000,000 men and women.

★ We have by far the largest peacetime armed force in our nation's history.

★ We have a predominantly youthful military establishment.

- ★ Of the total, one out of three is 21 or younger.
- ★ Approximately 2,000,000 are 25 or under.
- ★ Over 40% are 17 to 21.
- ★ One out of every six males 19 or 20 is currently serving in the Armed Forces.

Why are these statistics significant?

They represent an unprecedented situation. Never before have so many of the young men and women of our country served in a peacetime armed force.

In the foreseeable future, our Armed Forces will continue to be large.

Sizable concentrations of young men and women create special problems, both for them, the military and for the communities they visit.

Why must we do something about it?

The well-being of our Armed Forces is basic to our nation's existence.

Since we rely on our Armed Forces to protect our country these forces must be strong.

Without high morale, they cannot reach maximum effectiveness.

And we know that the morale of the military community is dependent to a large degree upon civilian morale and the understanding of the adjacent civilian communities.

Always concerned about our young people, we should provide services for all our youth—the most important item by far for an efficient military machine.

Many of the young men and women now in the Armed Forces will eventually return to civil life and play an important role in civil and community affairs. Today these same communities should welcome service personnel, protect their well-being, and prevent them from falling into situations which will lower their standards or cause them to seek undesirable company.

It is my personal opinion that during World War II many civilian communities and organizations did a tremendous job—in fact, a superior job—in seeing that members of the Armed Forces were provided with hospitable and diversified activities.

However, we must face facts, not fantasy. These are not World War II times now. This is 1952. Seven long eventful years have passed, full of changes and adjustments which in one way or another have materially affected all of us from the cradle to the grave.



We underestimate
the impact.

What are the difficulties resulting from these changing times?

Many people in civilian communities are uninformed and apathetic, completely indifferent to the problems of the military. Their only concern is whether they or their children will be required to serve in the Armed Forces.

Today we are involved in a struggle in Korea which results in the loss of many of our best soldiers. Because this action in Korea is considered to be a police action and is far removed from their door, many people have lost their patriotic motivations. They cannot conceive of the Korean fighting as an action which threatens their own life, home or well-being.

During World War II, when 10% of our population—15,000,000 men and women—were in the Armed Forces, many communities were accustomed to seeing great numbers of uniformed men and women. By comparison, they underestimate the present-day impact, especially since many of the military do not wear their uniform when off-duty. As a result, the public does not support adequately, with financial resources and interest, community programs for the young men and women of the services.

Let us analyze and study present-day youth

Numerous adverse influences resulting from World War II ties and postwar ties are found in the civilian background of the youth of today. These create special problems both for civilian communities and the Armed Forces.

We find young people have been subjected to difficulties and adjustments during their most impressionable period of development. Sur-

rounded by uncertainty and insecurity during their childhood and puberty, they have been branded with these influences. During the pre-World War II years, the actual war years and the postwar reorganization period, they have been required to adjust themselves to changes in the social order.

Even within the family group itself complex and difficult adjustments have been required. For one reason or another, schools in many instances have been unable to maintain the desired quality, curriculum and discipline. Some agencies and activities formerly so important in molding young men and women, in guiding them and providing them with leisure-time activities, have broken down in part or completely because of all-out World War II efforts and postwar reorganization.

As a result of these conditions, the adjustments of young people were repeatedly distracted and their activities had little supervision. Their thinking, attitudes and behavior pattern now tend to favor unreality. Because of some comic books, some posters, some movies and other sources of misinformation, they have formed erroneous ideas of military life and of their position as part of the military in a civilian community.

It is not surprising to find that these young people present a problem and a real challenge to all of us.

Many times they have morals without having a sound moral code or high standards of personal conduct. If they have a philosophy of life, it is highly materialistic. Their reaction is too often "What's in it for me?"

Many times they possess complete disregard for the value of property.



Many towns were hospitable in World War II.

Many times they accept responsibility reluctantly or grudgingly, or openly rebel. They are impulsive and too often exhibitionistic. They rationalize for personal gain or satisfaction. Often they are unwilling to follow through and think out a problem, hoping rather that some one else will figure it out.

However, don't let me mislead you. Fortunately, the majority of young people in the service are of the best—the finest—youth of our country. Most of our young men and women in the Armed Forces today have many wonderful traits and characteristics. They are impressionable, capable of hero worship, responsive to leadership and inventive in meeting immediate problems. They have morals beyond reproach.

With the coordinated help and assistance of associations such as the American Social Hygiene Association and the character guidance programs of the military, we will keep the majority of our youth as we desire them to be.

What do we need?

- ★ A preliminary program of training for young men and women prior to their induction into the services which gives them the necessary information about such matters as commercialized prostitution, cheap bars, etc.

- ★ A preinduction training program which stresses each young person's responsibility to his parents, his home, his community and the Armed Forces in serving his country.

- ★ A program which impresses upon the civilian population and upon young men and women prior to their induction the importance of *honorable* service to their country. Along this line, it will be necessary to inform the general public about the disgrace attached to an undesirable discharge from the service. The present acceptance by civilians of the individual who has a bad-conduct discharge or dishonorable discharge from the service must stop. This will eliminate the possibility of young people purposely getting into trouble while in the services for the express purpose of getting out, in order to shirk their responsibilities and obligations to their country.

- ★ A community-wide program of hospitality and diversified activities that will make service personnel feel at home and welcome in each civilian community.

- ★ Community recognition of the social welfare needs of military personnel and their families and a program to meet these needs.

- ★ Efficient utilization of all available resources, both in the civilian communities and the Armed Forces, to insure close coordination and cooperation with each other.

*Graduate of U. S. Military Academy.
Provost Marshal,
Headquarters, First Army.
Holder of Commendation Ribbon.
Colonel Lindsay P. Caywood, MPC --*



Our mutual objectives

★ To cooperate in keeping the morale, conduct and attitude of the young men and women in the Armed Forces at the highest possible standard.

★ To provide and maintain a healthy social environment for the citizen-service people.

★ To increase the security of our nation by raising and maintaining the morale of our Armed Forces.

★ To solidify the common interests of civil and military communities in order to afford the young people of our country a healthful, wholesome environment, free from evils which might threaten their well-being.



*Altogether,
they're
pretty fine.*



STRAIGHT TALK TO A SERVICEMAN

In February, 1951, the Journal of Social Hygiene reprinted with considerable satisfaction the text of a little folder called "Outsmart the Smart Guy!" as an example of the type of information made available to servicemen for their own protection. Since then, ASHA has distributed 138,950 copies of "Outsmart the Smart Guy" to military installations all over the country.

Perhaps the leaflet's chief virtue is its small, slender size. Slipped easily into a pocket, or read in a few moments while the new recruit stands in an endless line, the folder is worth many times its weight in its up-to-the-minute exposé of the ugly rackets that prey on young servicemen.

"Why Am I Being Interviewed?"—equally readable—is distributed by the Navy in its VD case-finding program. It tells the sailor how a complete contact report can break the chain of VD infection.

From time to time the Association plans to publish other materials prepared especially for the military and welcomes ideas and comments from readers.

WHY AM I BEING INTERVIEWED?

You are on the sick list because you have a venereal disease. Every case of venereal disease comes from another case, usually by sexual intercourse.

The person from whom you became infected was infected by another person. You may not know exactly which person infected you — in fact, if you have had sexual contact with several persons, you can never be sure from which one you caught venereal disease. It's possible, and it happens many times, that the girl doesn't know of her infection.

As you probably were giving off germs before your symptoms showed up, you too may possibly have passed infection on to one or more persons without knowing it.

Thus the chain of infection continues, and more and more persons become infected.

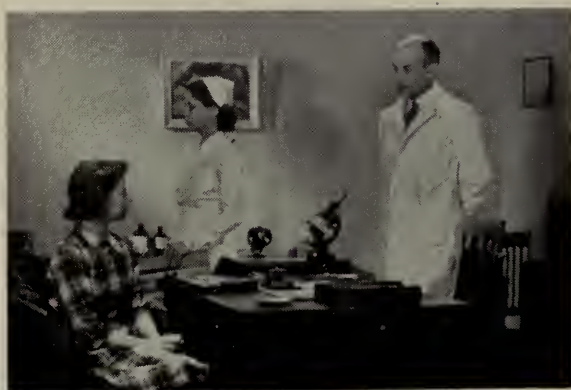
Since you have reported your infection to the medical department you will now be treated. But remember the girl who infected you. Also the others whom you may have infected. They will still go on infecting others unless they are examined . . . and treated if found to be infected.

You are in the key position to help to prevent further spread of infection. It is within your power to break up the chain of infection. Unless the girls are located, many of them will continue to infect other men, who will pass the infection still further, and increase the danger of venereal disease for everybody . . . including yourself.

Contact Information

You will be asked questions about your sex contacts. The information that you give will be furnished to the Public Health Service, so that these contacts may be located, examined and treated if necessary. This

*Mary saw
her doctor.
A test showed
she had syphilis.*





information is absolutely confidential, your name does not appear on it, and the contacts you name will be approached with greatest discretion.

You may have had only one sex contact and will wonder what will happen to her. Or you may wonder what happens to any contact named by you. You may be interested in seeing what actually did happen with the contact report naming Mary Jones.

Mary Jones was a contact for syphilis. The contact report gave her age as 19, a complete address, living at home with her parents and employed as a waitress. The investigator visited the address while Mary was home, introducing himself as a representative from the local health department.

Since Mary was alone, he stated, "It has been reported to the health department that you have been exposed to an infectious disease, and for your own protection and the protection of your friends, it is advisable that you report to either a private physician of your own choice or to the city health clinic for a medical examination and treatment if necessary."

Mary had a good idea of the nature of infections or communicable diseases and so agreed readily to report to her private physician. (The health department will of course check with this private physician, to be sure she actually reported.)

Should Mary's parents have been home and become inquisitive as to the nature of how she was exposed to the infectious disease, then the investigator would have replied with, "I don't know. I am not a doctor and since only a doctor is qualified to answer your questions, a visit to a private physician or health department clinic will supply your answer."

Mary Reports to Her Physician

Mary reported to her doctor and was examined and found to have both gonorrhea and syphilis. She was treated and she in turn gave information

to the physician on her sex contacts, so that they could be found and examined. The contacts then were treated at the first sign of infection. (As Mary was steadily employed, arrangements were made by the physician for her absence from work.)

Thus Mary was treated in a confidential manner, and her own health as well as that of many more people was protected. Since all her contacts were treated too, spread of infection from this source was stopped. This is one of the best methods now available for stamping out venereal disease.

A Minimum of Embarrassment

Methods of finding contacts are not absolutely alike throughout the United States, but except for minor variations the majority of contacts are handled just as Mary was. The girl is not embarrassed in front of anybody. She is only advised that she has been exposed and should be examined.

Remember that the information you give the interviewer will be kept strictly confidential, and the persons you name will not know who furnished their names. Nobody except the man you are going to talk to will know who gave the information. Contact reports will be kept within medical channels and at all times handled in confidence.

This is not telling on anybody. It is giving them very important advice with the minimum of embarrassment to all concerned.

The assistance of the law enforcement agencies is requested only when a contact who has been found to be infected refuses to report for treatment or when a contact repeatedly named as a source of infection has no permanent address and cannot be located by a health department investigator by himself.

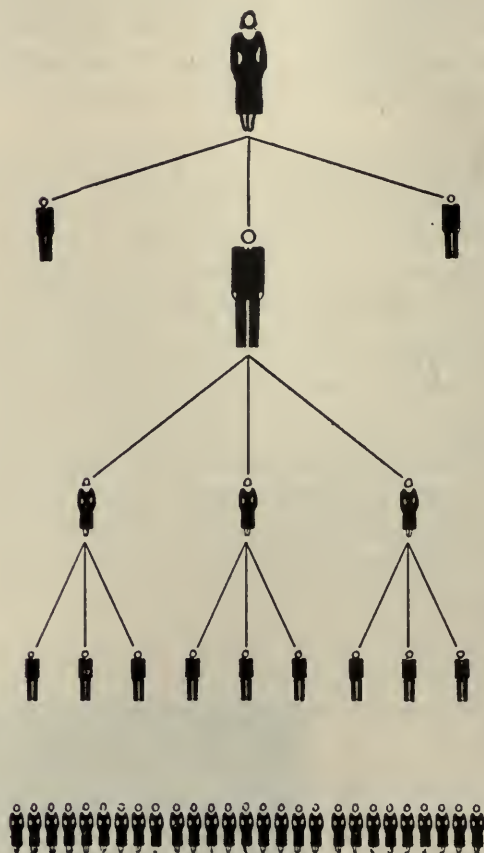
*All her contacts
were treated too.*



You Can Break the Chain

When you supply the information requested on a contact report, you not only get the contact under medical care but also do your part in making the venereal disease control program of the Navy a success by helping to find and eliminate all suspected sources of infection.

The elimination of a single case of venereal disease may break a link in a long chain of infections.



*Each case of
venereal disease
comes from another
— the purpose of
finding all contacts
is to break the chain
and prevent further
spread of infection.*



Where There's a Will, There's a WHO Way

Cultures are diverse. In this truism lies the crux of the international venereal disease control problem.

You can't send out a technically proficient team of VD experts, equip them with the latest drugs, assign them to a remote area, and expect them to do an efficient, speedy job right off. First they have to learn to know and like the people among whom they are going to work.

Peoples react differently in solving their problems. Some scorn tradition, embrace change as a remedy for past evils, look to the future with child-like faith, even call a drug "the miracle drug." Others tend to cling more to tradition, fear change, suspect the new, and look to time-tried remedies to make them well.

Posters, movies, the latest drug, government sanction—all these may win the attention and approval of one group and the indifference or even hostility of another.

This problem of difference must be faced. In each country there are particular social, economic, cultural and religious patterns that must be understood before the chameleon of world-wide venereal disease control can be tackled.

A Coordinating Agency

All countries have VD problems in common. All can share in the successes and profit from the failures of the various national VD control programs. The need for a global framework to pool international resources is satisfied in the World Health Organization of the United Nations.

WHO provides countries with experts, equipment, drugs and other facilities, grants fellowships, helps set up national training programs, acts as a clearing-house for modern research, makes available these findings to all governments.

It is WHO's job to correlate the efforts being made throughout the world to control VD. It is WHO's job to generalize and improve upon these efforts, never losing sight of the fact that what affects one area today will ultimately affect another area tomorrow.

Because sex is universal, VD is a global problem. There is no way of quarantining sex, of isolating it, of denying its entry into a country. Customs officials and inoculation specialists may work to restrict the spread of other undesirable imports, but the misuse of sex—with its far-reaching consequences—is immune to such control. In this age of easy transportation and giant movements of people, isolated VD control efforts can lead only to dispersed and dissipated results, temporary remedies.

In exploring the diverse methods in use, the WHO recognizes that innumerable communities have no control measures other than those inherent in the cultural pattern. Some rely principally on medical care. Others look to religion as an effective deterrent. Still others depend on case-finding and legal regulations.

No single approach has been adequate. Diversity and disharmony of method have only frustrated the overall purpose. It is no wonder that the disease has spread from person to person, culture to culture, country to country, faster than man has been able to arrest it.

More Than a Clinical Problem

VD is unique among microbiotic infections in that it is not wholly a clinical problem. Its roots lie in socially unacceptable environments, its manifestations are always accompanied by social maladjustment. We ride the periphery when we regard only the clinical aspects and forget the deeper causes.

Hence sociologists and those skilled in human relations are indispensable to syphilologists for wise modification and correlation of method. Without such assistance there is a tendency to try to transplant a set formula of control that may have proved adequate elsewhere, force it on a new community, show impatience when it is not readily accepted. The net result is temporary deadlock.

But so cavalier an approach does injury of a far more insidious nature—it creates a stone wall of opposition that corrective measures cannot tear down, it has reverberations on other health programs that must labor to regain the lost faith of nationals, nationals who have learned to discount much that is imported under the label of international assistance.

A syphilis control program must be related—not separated from—the full program of health service. Of initial concern to this service is the economic and emotional disposition of a given community. It is this factor and not race that governs the incidence of syphilis.

Although certain racial groups may have a higher degree of infection in a particular locality, closer analysis finds this racial element to be only incidental, the real cause being economic. Such disruptive factors as unemployment, overcrowding and instability are thrust upon a group irrespective of race, and they invite a high incidence of syphilis.

A Basic Need for Stability

A stable community is the strongest bulwark against the spread of syphilis. Migrations, large or small, carry with them the seed of disease. Consider the merchant seaman. Separated from normal family life, he may seek compensation in sexual promiscuity and thereby play no small part in the international prevalence of venereal infection.

Syphilis has spread from a localized area throughout the world, whether by Columbus's men, wandering armies or seafaring drifters it doesn't matter. The tremendous migrations of World War II, the more localized roving of the Bedouins in the Middle East, the increasing industrialization of the area with its disruption of village life—all these have an impact on rising syphilis rates.

There are some Middle Eastern groups which, though they live in close proximity to highly infected tribes and endure the same social and hygienic deprivations, nevertheless remain uninfected. The answer must lie in their relative stability, in their refusal to mingle outside their clan. The low rate of syphilitic infection among the Jewish population, in spite of their long wanderings, is a documented fact. Such is the immunizing power of established family unity and the feeling of place and security within the family circle.

Amazing, too, is the low rate of syphilis among the Arabs in the refugee camps of the Middle East. Despite their pathetic overcrowding and unbelievable poverty, despite families and communities cut adrift for two years, they still have very little syphilis. The deterrent is religion, the Moslem code prescribing strict conduct of family life.

Prostitution with its adjunct, VD, is a particularly virulent manifestation of family instability. Studies made by the Health Department of Puerto Rico in 1944 and at the Cairo Lock Hospital in 1948 support the conclusion that prostitution is primarily a matter of economic insecurity, an insecurity which bites at the root of the family group. Instead of treating prostitutes merely as clinical cases, an effort must be made to rehabilitate them, to give them a means of earning their own living constructively or of enjoying a normal family life.

Broken homes and divorced or separated parents play their part, too, in the syphilis story. Child victims of this disruption experience an early loss of security, a frustration that is carried over into adult life in terms of illicit sexual activity. Wherever divorce is a common practice, lack of family continuity thwarts both men and women and is the principal mainspring of promiscuity.

A syphilis control program must reach all these people, the migrants, the industrial workers, the unemployed and the unemployables, the disunited and rootless. Once these people are reached, once their sympathies are won, treatment can be begun.

It is now within the power of all governments to plan ahead with the World Health Organization to establish treatment facilities. Training of personnel and the establishment of demonstration centers are emphasized by WHO along with the loan of drugs, equipment and other facilities to begin the program. Adequate clinic resources reduce the reservoir of infection and lessen the hazards of infectious syphilis.

The Necessity for Health Education

But reliance must not be placed on treatment alone. Treatment can't guarantee 100% case-finding, it can't guarantee 100% cure. As Dr. John H. Stokes points out, "The modern plan for control of venereal disease fails because re-exposure and re-infection cannot be controlled, contacts are difficult to find, preventive treatment cannot be enforced, a 100% cure is not available and if rapid cure results there is no chance to build immunity."

With the advent of the antibiotics, syphilis is no longer considered the elusive plague it was under the metals and arsenicals. But the rapidity of cure breeds a nonchalance about the severity of the disease. We must, through health education, replace the old-time dread with understanding.

If the citizens of a community are to work together toward the solution of the syphilis problem, they must become aware of its nature and the methods of control. Health educators must assume a positive attitude, guide the people's interest along constructive channels of treatment and prevention—not frighten them into hurried action. As a part of intensive rural hygienic work carried out in Dutch Java, the people attacked the syphilis problem as it was related to the whole health service program.

A fine example of a health education pilot project in which VD control played a related part and in which the local community participated was conducted in three villages in Egypt. The villages were selected because they were situated near WHO's Tanta Demonstration Center, operated by the Egyptian Ministry of Public Health.

To secure cooperation, it was decided from the beginning that a council consisting of key Egyptians in health, law, social work, education and commerce should act as advisers to the WHO team in its program planning. Snags which might arise from disregard for local customs could thus be ironed out beforehand.

Adjustment of foreign ideas and techniques to the culture and religious framework of the local community were guaranteed by:

- Establishing a program to continue after the demonstration was completed.
- Arranging community contacts for the WHO team.
- Raising the standards of professional health work by coordinating community agencies.
- Asking local people to help plan and develop the WHO demonstration work in Egypt.

It is significant that several women were members of the council — this in a country where women do not often take part in affairs outside the home. Eventually, it is hoped, the council will grow into a working social hygiene association — this in a country where there are few private agencies.

The clinic at Tanta is built on modern lines and has developed a program within the limitations of the government's ability to carry it on after the team leaves at the end of two years. Each expert has an Egyptian understudy who will be able to take his place. Training seminars and institutes are conducted for nurses, doctors, social workers and public health workers. No temporary expedient is this project.

To provide a gauge for planning this long-time program in social health, a short-time experimental project in health education was conducted in the three villages previously referred to.

All community resources were gathered together and coordinated with all community agencies. Skilled social workers and educators worked with local people familiar with local peculiarities, to avoid duplication of effort and to insure cooperation. The focus of the plan was on the home and the mother, and the scope was limited to the means the people had for action.

Three governmental ministries sponsored the project—the Ministry of Public Health through the Tanta VD Control Demonstration Center, the Ministry of Education through the School of Social Work for Girls, and the Ministry of Social Affairs through the Fellah Department (village social centers). The group was extremely fortunate to have the services of nine girls from the School of Social Work, who could enter the homes and talk to the mothers.

Well-Laid Plans

Overall planning was done by these three government agencies and the students. Specific planning was done by the students, the local health committee and the staffs of village social centers. After three months of preliminary study, an outline was formulated to represent the actual *felt* needs of the villages, not hypothetical ones.

The planning committees studied other programs, especially the Arab refugee health education program, analyzed the special functions of each agency to avoid overlapping, stressed approaches—how to motivate people to change, how to meet people, how to make a successful home visit. This part of the training paid rich dividends.

They took photographs of the villages and the people living in them. They pasted these in “Lap Books,” which the girls carried into the homes to show to the mothers. How they chattered and laughed when they recognized spots in their own village, when they identified a village character! The girls could have had no better entrée. These mothers couldn’t read, they had no use for pamphlets, they couldn’t understand a movie, but they could understand a health menace when it was pictured and explained to them by the girls.

When they first entered the villages, these Egyptian girls faced all kinds of false rumors. But when they adopted the life of the village, spoke the local dialect, modified their dress, treated the people kindly and respected their customs, showed sympathy for their problems, when they did these things, they had no difficulty in gaining the confidence of the people. No foreigner, however well-meaning, could align herself with the women and do the job these girls did. Nor could a male worker do it.

As one man said, “Because we are men, we cannot reform what is inside the houses. We are unable to contact the ladies on whom depends

the reformation . . . but the presence of the girl social workers has been a vital complement to our work."

The girls, however, met stubborn resistance when they tried to hold meetings and form committees with these mothers. Work in the fields, care of children, opposition of husbands, the tradition of woman's place — all these militated against their leading an organized movement to improve family health.

They Welcomed Blood Tests

Pregnant women would come to the clinic for blood tests and examinations, but wouldn't have their babies delivered outside the home. For positive cases, clinical and social examinations were provided and rapid penicillin therapy was administered. In spite of all manner of difficulties, the attendance of pregnant women for blood-testing and the regular attendance of positive cases for treatment were beyond all expectations.

After teams from the Tanta VD Center had visited each village on a certain day for blood samples, they found 2.07% positive.

Several times each week the health committees met to help the girls and to offer needed materials at half cost. With the help of the staff of the social centers they found solutions for most of the girls' problems. Always the people were encouraged to do things by themselves, for themselves.



In evaluating the program it was found:

- That careful supervision and planning were vastly worthwhile.
- That good cooperation could exist between the local health committee and foreign health workers.
- That the sympathetic publicity given by the Cairo press was an excellent aid.
- That the aims were realistic.
- That the technique of home visits was the correct approach to the problem.

Room for Improvement

Even more satisfying results could have been obtained if there had been:

- More careful planning for the use of governmental employees in the villages.
- More publicity on the village level regarding the aim of the program.
- A clearer definition of each supervisor's role.
- A clearer definition of each agency's role.
- More coordination between the staff of the village social centers and the girls.
- More careful planning of the pre-service training in order to avoid repetition.
- More time free from clerical reporting for the social worker.

Such an evaluation will prove to be of tremendous value in preparing other programs for other Egyptian villages.

This is the story of three small villages in a relatively poor country. This is what can be done with limited personnel, limited supplies and limited funds. It is an axiom that much can be done by the people of a country if a little is done by the WHO. What many countries need is some monetary and much technical assistance. Given these, they can proceed in their own way on a community clean-up job that will have reverberations throughout the world.

But unless the local people themselves play an active part in an anti-VD program, syphilis cannot be controlled. Unless all efforts are mobilized — governmental and voluntary alike — unless their efforts are coordinated with those of the international agencies, syphilis will remain buried in the labyrinth of the social and cultural pattern of a community.

BOOK NOTES

Elizabeth B. McQuaid

Sex and the Law, by Morris Ploscowe. New York, Prentice-Hall, 1951. 310p. \$3.95.

Here is a useful, interesting and seemingly authoritative book on our laws dealing with sex, sex crimes, marriage, divorce, illegitimacy and prostitution and how these laws affect us as individuals and the society of which we are parts. Its writer, a New York City magistrate, has contributed other articles on the legal aspects of sex and (quoting the publishers) "he is an author of the famous Kefauver Committee report on crime in the United States."

This is not a dry legal tome requiring study that would penalize rather than reward the lay peruser. Rather, it is a volume wherein fact and philosophy are so interwoven as to provide both graphic reading and valuable reference.

One has but to scan the 40 pages of the third chapter, for example, to realize the hodgepodge of chicanery now existing in divorce legislation and administration. As Nelson says in the second edition of *Divorce and Annulment*, "The tendency of recent years has been to expand the grounds for divorce in most states. . . . It is quite obvious from the nature of the provisions in some states that they are actually bidding for transitory divorce business in like manner as other states advertise their scenic beauties to attract tourists."

An eloquent introduction by one of the nation's great legal educators and statesmen, Roscoe Pound, outlines saliently the need for and values of the book. Limited review space doesn't permit any expanded comments on the entire 10 chapters on marriage; annulment; divorce; illegitimacy; fornication, adultery and indecent exposure; rape, homosexuality, sodomy and crimes against nature; psychopathic-sex-offender laws and crimes against children; prostitution; and marriage, sex crime and social policy.

Any serious student of sexual phenomena and all persons whose professional pursuits necessitate some dealings with problems involving sex will find this book a worthwhile acquisition.

Ray H. Everett, Executive Secretary
Social Hygiene Society of the District of Columbia

The Adolescent, by Marynia F. Farnham, M.D. New York, Harper, 1951.
244p. \$3.00.

The literature on the adolescent age is, I feel, considerably enriched by this contribution. Dr. Farnham writes in a pungent, easily read fashion concerning the whole gamut of teenage development from physical growth through emotional, social, economic and sexual growth and then goes on to the less frequently included topics of delinquency, homosexuality, neuroses and psychoses, with a final chapter of directives for parents and other adults.

It is in these last chapters that Dr. Farnham's book becomes something more than just another guide to adolescence. Here she draws upon her experience as a practicing psychiatrist and offers many dramatic illustrations from her professional experience. In most instances we accept her interpretation of them and feel with her that "it could happen here."

The book is not a primer. There are passages that one must be prepared for as a college student must be prepared for a course in advanced economics or comparative religions. As Dr. Farnham says, we as a society have turned away from certain occurrences and refuse to face them. With genuine feeling she commands us to cease escaping and to face reality.

The book has not only an index but a most trustworthy and enticing bibliography for future reference. Dr. Farnham is to be congratulated on writing a truly courageous book which cannot but awaken new thoughts on old but ever-present situations in a changing world.

Frances Bruce Strain
Author, educator, lecturer

Selected Papers in Casework. Raleigh, Health Publications Institute, 1951. 176p. \$1.75.

Twenty-one papers presented at the National Conference of Social Work in 1951 are collected in this volume.

Social hygienists will find of particular interest "Education for Responsible Parenthood," by Grace Mayberg; "Marital Counseling in a Family Service Agency," by Eleanor A. Moore; "Casework Services Today in Institutions for Delinquent Children," by Norman V. Lourie; and "The Use of Foster Homes in the Care of Unmarried Mothers," by Dorothy Hutchinson.



journal of SOCIAL HYGIENE

Vol. 38

June 1952

No. 6

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About our cover . . .

An English family on the beach at Skegness on Britain's east coast. Fifteenth of a series of Journal covers on family life . . . photograph courtesy of British Information Services.

Harriett Scantland, Editor

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THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association. Subscription price: \$3.00 per year. Single copy: 35¢.



The ramparts we watch

by Governor Henry F. Schricker

A speech for Social Hygiene Day in Indianapolis April 29, 1952

For the third time in 34 years—only the span of a young man's life—our country is conscripting young men into the Armed Forces of the nation. In World War I, and in the terrible war only a few years past, our forces vanquished the enemy, and we pray that the present conflict too may be successfully resolved.

Now, as then, our defense lies with the young men of our nation. What are we giving them besides a uniform and our hopes and prayers? The strongest armor we can give them is strong bodies, minds and spirits—and the belief that their nation, their communities and their homes are worth fighting for, worth coming home to. We spend billions on the modern mechanization of our fighting forces, billions on atomic weapons and the other materials for making war today. What are we spending in the coin of conscience to fit young men for the tremendous task we have given them?

Are we, through indolence, allowing their youthful vigor to be dissipated by disease, their youthful ideals to be contaminated by community conditions which defile all that is best in human nature and exalt that which is base?

Social hygiene is a program which attacks some of the oldest and ugliest of the ills that befall our society—venereal disease and sexual debasement. For many years, respectable people turned away in horror from consideration of such seamy problems . . . and the problems grew like rank weeds in an untended garden. That time of intentioned oblivion is now past, thank God. Those of us who yearn, with deep conscience, for the better world we know is within our grasp, attack these problems as we do others which beset our society today.

I have been asked, as Governor of Indiana, to share with you my impressions of where we in Indiana stand in regard to these problems—a kind of “State of the State” message. In order to obtain current factual data on these interrelated evils, I have turned to those of our state agencies which have responsibility for certain aspects of the problems.

VD is still with us

The picture which I glean from the information given me is not all black by any means. In fact, there is much progress to be noted from facts gathered by our Indiana State Board of Health. However, much remains to be done in controlling the spread of venereal disease.

Without any intent to be a scaremonger, I know facts indicate that the present status of venereal disease control is such that it has engendered



*Their clear eyes
hold many questions.
Ambivalence
is not the answer.*

a wave of ill-advised optimism or complacency. To examine the current situation in Indiana realistically, we can note that venereal disease remains a medical and social problem.

Now complacency may stem from the fact that our new drugs have formed a widely heralded defense battery against the inroads of these diseases. We are repeatedly cautioned that penicillin is not a panacea which will deliver us from the ravages of venereal diseases. In 1951, the Indiana State Medical Association and the State Board of Health devised a plan for the distribution of penicillin for the treatment of syphilis for the medically indigent. In the first eight months of the operation of this program, the State Board of Health distributed enough penicillin to treat over 2,000 cases of syphilis.

See no evil

Until the '30's, none of the venereal diseases could be mentioned publicly. This attitude, that the diseases were unmentionable, tended to induce a feeling that they, therefore, did not exist. Many people who would not admit to their existence were led innocently to the assumption that the venereal diseases were as far from their sphere as the planets.

Two examples right here in our own state will serve to indicate that this is specious reasoning. Not many months ago, the Indiana State Board of Health was notified of the existence of several cases of venereal disease in one community. Through the cooperation of local physicians and the citizens of this community, the State Board of Health interviewed many of these cases. During this investigation, some startling facts were revealed.

The Board of Health received notification that there were cases of syphilis in Illinois and that contacts of these cases had been reported in Indiana. The investigation made subsequent to this notification indicated that there were three cases of primary syphilis in this state arising as a direct result of the Illinois cases.

They played with fire

Early in 1952, the Board of Health was called upon in another locality to help in locating contacts among some young people in Indiana who were ill with a venereal disease. Investigation revealed that these young folks were 12 to 16. To check the spread of the disease, the local health officer, assisted by trained interviewers from the Board of Health, interviewed several girls.

One of these children, only 14 years old, named 32 sexual contacts. The time interval covered by these 32 contacts was approximately one month. Five additional girls were interviewed, and these six children named over 100 sexual contacts.

As a result of this investigation, the doctors in the area found and brought to treatment a number of cases of gonorrhea.

I am happy to report that this outbreak has been checked through the alertness and cooperative effort of the physicians and the health authorities. Recognizing the possible background of this outbreak, the State Board of Health and the citizens are planning an educational program designed to prevent the recurrence of such a situation.

Although the general trend of syphilis infections in Indiana follows the national pattern of a downward movement, I cannot say I have been told that the same is true for gonorrhea. In this latter disease, the trend in the state is upward.

In 1941, 352 cases of congenital syphilis were reported in Indiana. Ten years later, in 1951, 262 cases were reported. These are merely cold figures, but back of them lies the undeniable fact that in 1951 in Indiana 262 babies were born with syphilis which they had contracted in their innocence.

Case-finding

As the occurrence of syphilis decreases, the single and specific case is, of course, more difficult to locate. To locate cases of syphilis it is necessary to interview, to find contacts and to get both cases and contacts to their doctors. The busy practicing physician has but little time to devote to this time-consuming project.

The State Board of Health maintains a staff of trained interviewer-investigators. They interview no patient without prior consideration of the physician. Their concern is to get the individual—whether he be



Penicillin for 2000 cases.

a case or a contact—to the physician of his choice and so under treatment to prevent the spread of the disease. This can be done only when the physician who treats a case of syphilis reports that to his State Board of Health on the confidential form provided.

Then the Board of Health can, with the approval of the physician, locate the patient's contacts and get them under a doctor's care.

*Hoosier Democrat in the
Horatio Alger tradition.
Former lawyer, editor, banker,
state senator, lieutenant governor.*

Governor Henry F. Schricker of Indiana



Thus it will be seen that this problem reverts directly to local civic consciousness. Your State Board of Health stands ready to offer its entire facilities to any community that recognizes the problem and wants to do something about it.

Now, as to the related problems with which we are concerned—commercialized prostitution and sexual delinquency—they are more difficult to report. Most of our Indiana cities abolished segregated, or “red-light,” districts during World War II. This reform was carried through on a wave of patriotic concern for the health and moral welfare of our men in the service.

Most of our cities and towns, having rid themselves of the stigma of tolerated prostitution, have determinedly fought its return, and successfully. In some others, an insidious beginning has been made toward the re-establishment of tolerated houses of prostitution.

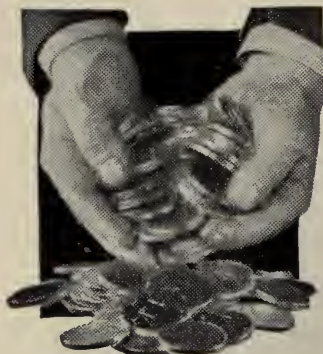
I presume that it is known to everyone present here that we have laws prohibiting such business enterprises. We have laws against gambling also, yet this vice flourishes where vigorous prosecution of the law is absent.

Gambling and prostitution

It is not surprising to anyone who gives more than casual consideration to the subject, to find that prostitution and gambling are often co-existent. The structure of law enforcement is like a dike—one leak, and the dike is weakened, and other cracks inevitably appear. Once these two evils creep into the body politic, they begin to feed each other.

Gambling spots and houses of prostitution, both being outside the law, operate in a furtive atmosphere which attracts persons with anti-social tendencies. Crimes of violence are often plotted in these holes of iniquity. The role of the prostitute as an informer for the enemy is part of military history.

Underworld forces are at work everywhere, attempting to stage a comeback for tolerated prostitution, for it is a very profitable business in itself.



*Prostitution
cannot exist
without
hush-money.*

Open sesame to other evils

Furthermore, the house of prostitution opens up a constellation of subsidiary rackets, such as blackmail and extortion. It enables the dirty hands of the underworld to put hush-money into pockets of police and other law enforcement officers . . . for unlawful business cannot exist without the giving and taking of bribes.

It causes venereal disease rates to skyrocket, for the old fallacy that a promiscuous woman can be kept free of disease has long since been exploded by medical findings. What folly it is to spend our public funds for our progressive and successful program of venereal disease control and yet tolerate conditions which go far to nullify our progress in public health control!

There are apologists for the red-light districts. Well-meaning but ill-informed persons sometimes argue that the segregated district keeps all sexual vice within bounds, that the closing of a red-light district creates an increase in crimes of violence, in assaults and rape. This is not true, for careful studies made by the American Social Hygiene Association prove that whenever a red-light district is closed down the major as well as the petty crime rate decreases.

Our youth

More important than any of the above, however, is the moral deterioration of our young people which is encouraged by prostitution. Recently I read a newspaper article which described a teen-aged gang said to be blackmailing patrons of a house of prostitution in one of our Indiana cities. There is a lesson in that story for those with eyes to see it. A community which condones law violation, as represented by prostitution, is deliberately corrupting its youth.

The question of what kind of moral attitudes our young people are absorbing concerns us deeply, for the teen-agers of today will be the

fathers and mothers of the next generation. What kind of families will they found and rear? In the answer to that question lies our whole future, for the family is the foundation stone of all society.

Literally, these young people of today hold our fate in their hands. What are we doing to steady their hands and to guide their aspirations toward clean living and high thinking?

Let us try to analyze some of the forces which are molding the moral fiber of our young people today. We are bound to say that much of what the clear eye of youth sees today is negative. Such conditions as I have described above are certainly deleterious to moral and spiritual welfare.

As Governor of Indiana, I am deeply ashamed that in certain of our Indiana cities such conditions still prevail. I can decry them, but I neither personally nor in my official capacity can change them.

Good laws need good citizens

The resources of our state agencies for health and law enforcement are available to all, but state enforcement of our health and legal codes is not the answer. The state police have in the past raided numerous truck stops and trailer courts and put a stop to illicit activities in such places. But they will crop up again wherever local sentiment condones or tolerates conditions of this kind.

Another state agency which is helpful in maintaining decency and order is the Indiana Alcoholic Beverage Commission. Tavern owners or proprietors are subject to regulations as to the conduct of their business, and their licenses are revoked by the A. B. C. when the regulations are not complied with. One of the responsibilities put upon the tavern owner is to keep promiscuous and loose men and women out of his establishment.

There are in Indiana 80 excise officers of the A. B. C. to enforce this and other regulations, such as selling to minors, adhering to the legal closing hours and so forth. Almost 8,000 retail outlets dispense alcoholic beverages. It is apparent that with the best will in the world, 80 officers could not catch every violation on their routine trips of inspection. However, upon complaint of local citizens, immediate action can be taken against violators.

This highlights a truth known to all of us, that only in a police state can people be compelled to obey a law or dictum 100%. In a democracy, the pressures for conformity and obedience to the law come mainly from the determination of honest citizens to rear their families in a decent and law-abiding community—such people as you who are here tonight, who attend meetings of this sort motivated by a desire to be helpful in creating the kind of communities we want.

Delinquency, detection and divorce

We hear much these days about the deplorable morals of our young people, and there are some who would claim that sexual delinquency has mounted to an alarming degree.

Before we condemn, however, we might well ask if some of the reported increase is not due to the heightened and more enlightened work of the agencies which deal with the problem. As with physical disease, when a program of detection is stepped up, the reported rate of that disease climbs. If this is the case with the social disease of delinquency, we should be gratified, not alarmed, that our juvenile courts are finding and trying to straighten out these tangled young lives.

In seeking to rehabilitate these young people, modern probation work digs below the surface for causes. There we find, more often than not, the broken or the inadequate home.



*Good parents are
good ramparts.*



Charles Boswell, chief probation officer of the Marion County Juvenile Court and a member of the Indianapolis Social Hygiene Association, has this to say: "In dealing with the juvenile sex offender, I see one factor which stands out in the causation pattern—the chief satisfaction these girls were getting from their escapades was simply—fellowship! It appeared that their families had failed them in filling their need for affection. We are seeing a return of the 'victory girl.'"

And J. Edgar Hoover, director of the Federal Bureau of Investigation, has written, "Delinquency is increased by parents who are too busy with their own pleasures to give sufficient time, companionship and interest to their children."

Careless parenthood and broken homes spawn only weak incompetents, not the strong defenders we need today!

In this connection, a look at divorce statistics is revealing. After a postwar drop in divorce proceedings, they are again climbing. In Marion County, for instance, there was an increase of 12% in divorces granted in 1951 over 1950.

This is a sad reflection on the uneasy time in which we live. Wage-earners are on the move again, drawn by the magnet of defense industries . . . the same magnet which takes mothers away from their homes

and into the factories. Thus we have social casualties as well as wounds incurred in warfare.

What will happen to the Hoosier family in this troubled era when the old familiar fabric of family life is so strained and torn?

From the *Christian Century* we take some heartening advice, "In these days of gathering gloom, there are four things we can do with our hands—wring them, fold them, put them in our pockets, or lay them on some job that needs to be done."

Through labor

The Indianapolis Social Hygiene Association has seen a job that needs to be done and has laid hands upon it. Continuing work for strengthened law enforcement and health education is bringing results, slowly but surely. Social hygiene, working with our churches and our schools on programs for family life education and counseling, seeks to draw back into the family the strength perhaps not needed in an easier day.

There is a part for all of us in this job of building our first line of defense—strong, clean communities and homes. Let us put our hearts into the job.

CREDITS

Department of Defense Photos, p. 241, 274.

Harvey Patteson & Son Photographers, courtesy of San Antonio Chamber of Commerce, p. 250.

Elicson Photographer, p. 252, 256.

John Rose Portraits, Hutchcraft Studio, p. 254.

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Conway Studios, N. Y., p. 266.



Polls Open . . . Brothels Close

San Antonio Breaks with Tradition

by Elizabeth McQuaid

Twisting and turning roguishly about the city, the San Antonio River scorns the adage about a straight line and follows in its own good time its traditional path to the sea.

So it has been with San Antonio's history. Never dull, always individual, it burgeoned from Indian beginnings, borrowed from the Spanish their culture and emerged from its frontier days into a period of unholy politics and laxity that, except for a wartime era of lily-whiteness, blazoned San Antonio across the nation as one of the three worst cities for toleration of open vice.

That is, until June 1, 1951. On that day a new set of officials was sworn in on a platform that pledged local governmental reform and the adoption of a new city charter providing for a council-manager form of government. In an incredibly short time a freshly organized police department was enforcing laws that had long lain dormant. Today, just about a year afterward, San Antonio's citizens are congratulating themselves on the "excellent" rating they have earned from the American Social Hygiene Association for wiping out vice.

The door to San Antonio's riotous past is padlocked as tightly as are the doors of her red-light district. No longer do the gay ladies of Metamoras Street beckon to many of the 100,000 servicemen based around the city. Prostitutes, panderers and narcotics peddlers, who only last year shook their heads in dismay at the closing order, have now deserted the town.

The dramatic closing of the "district"—swift, decisive though it was—came as the final step in a long, slow evolution in public thinking.

For generations

For generations San Antonio had complacently nursed the tradition of the wide-open town. Its citizens ignored the taxi drivers and bellboys who doubled as panderers, the good-time girls and other underworldlings who swarmed on the city, following the easy-money lure. Even newspapers froze into silence over San Antonio's prostitution and venereal disease.

If an occasional citizen did pause to consider prostitution, he condoned its evils with the old dodge—"It's necessary." How else could you handle servicemen surging into town, casting off the discipline of the base? How else protect your women?

Granted that open and flagrant prostitution had best be suppressed—grossly unrealistic notion—how could you dig out the entrenched political machine that oiled its wheels with profits from vice rackets?

No, the average citizen a few years ago shrugged his shoulders and went his way.

San Antonio was good enough for him, he thought, as he watched its river flowing quietly between green banks past palm and pecan trees. His city, proud of that river, dredged it to a rural freshness, arched it with 40 bridges.

He passed the Alamo, resting in its garden setting, thickly walled off from the city. Within lay the mementoes of Crockett, Bowie, Travis—heroes all. Overhead a winter sun warmed the town to a faultless 76 degrees.

A little farther away, ringing San Antonio in a half-circle, tranquil Franciscan missions retained the bare, clean flavor of the past. And much of San Antonio's past was good.

The cocoon was cracking

But above the missions planes roared, and on the outskirts of the city vast military bases mushroomed. Texans hurried through Alamo Plaza toward Joske's department store or, in the opposite direction, toward the massive post office building.

The past was still there. But it was being submerged in the present which, with its insistent social demands, would inevitably catch San Antonio up in its current.

True, the city had had its share of momentary reforms, concessions to political expediency, even one period of law enforcement that lasted



**Families now
occupy these
one-time cribs.**

as long as one man was in power. It had had its share, too, of incompetent politicians notable only for their vigorous pursuit of the unsavory dollar.

One energetic individual comes to mind. His "clean-up" of the prostitution district was literally that and nothing else. With mop and broom, new lineoleum and deodorant, he renovated the cribs—one-room shacks rented by prostitutes on the west side of town—and cut down VD rates about as effectively as if he had sprinkled around athletes' foot powder.

P. L. Anderson

Of a different caliber was the reform of wartime Police Commissioner P. L. Anderson. With brisk anecdote he'll tell you of his decision to close the district. One afternoon in a brief directive to his force, he closed the houses for the duration of his administration.

"That was no reform," he'll snap. "I'm no reformer. I merely enforced the law."

And that he did, until the madams and their retinue conceded that the heat was really on. "The heat wasn't on," says P. L., with a twinkle, "it was a permanent temperature."

For his service to the Armed Forces, he received a commendation from Secretary of War Stimson and a citation from General Wainwright.

Smilingly he recalls another "honor" he had previously received—a charter membership in the "Research Clinic of America"—the building where it was housed still flaunts these words in giant letters across its wall. Purporting to have a preventive and cure for syphilis, the head of the clinic hoodwinked the city for some time before his cure was found to be fraudulent.

"It was a genteel racket, set out nice-like," P. L. drawls.

Today he says of prostitution, "There's no sense in regulating a thing that's vicious. If it were just the lone girl by herself, maybe it could be looked upon as a human frailty. But with panderers and financial backing, it's such an ugly thing. . . ."

This is the opinion of a man who recalls the days when there were only 96,000 Texans in San Antonio. "They stood on their rights and whatever they did was right. Concerted endeavor was unthought of. VD and prostitution were accepted, a boy had his fling and went to Hot Springs."

By 1951 San Antonio's citizens had come a long way when they elected a new administration pledged to close a town that had burst wide open when P. L. no longer held office.

The resistless surge

This 1951 clean-up was no political whitewashing, no military expedient to lower VD rates, no one-man crusade. It was an upsurge of public indignation against corruption in government. It came about through the concerted effort of a governmental research expert, a citizen-supported, independent planning board, a citizens' political action committee, the American Social Hygiene Association, the clergy, the military, the police, the plain people of San Antonio.

One of the men behind this revolution is Edward G. Conroy, director of San Antonio's Bureau of Governmental Research, a scholarly man of tremendous tenacity. In recognition of his service for better municipal government, he recently received the "San Antonio Award for Civic Service for 1951" from the Citizens Committee for Council-Manager Government.

Edward G. Conroy



As far back as 1934, Conroy, as a public-spirited citizen, had dreamed of establishing a government research bureau in his native city and had begun to lay the groundwork for a career that would eventually reform that city's administrative framework.

His enlightened council-manager plan suffered an early defeat at the polls in 1940. The charter which he drafted twice suffered a like fate.



Lt. Col. George M. Roper

But today a charter basically the same as this original one is in force in San Antonio.

In the meantime Conroy met with advocates of the council-manager idea. He set out to impress upon local business leaders the need for a governmental research bureau if there was ever to be a long-range program of local governmental planning. His efforts bore fruit in 1948 when he was invited to establish a bureau.

Time to strike

At last circumstances, so often stubborn, began to play into his hands. The tinder that was to inflame public resentment to the point where it cast out the old commission plan of city government was a defunct public hospital, left unsupported by the city political machine.

By 1948 San Antonio was without a public hospital of any kind.

With Conroy and his friends agitating for municipal funds and with the mayor and his councilmen refusing them, the newspaper gleefully picked up the controversy. Public opinion swung over to Conroy's side.

The mayor, highly incensed over efforts to further the council-manager plan, hurled a challenge at the reform leaders to run a candidate for mayor. Hastily they put up a candidate—reluctant Jack White. Enthusiastic voters swept him into office on June 1, 1949, to head as hostile a council as a mayor ever faced. Within two years he was to lead a whole reform slate into office.

By 1951 Conroy had assisted in bringing dissident council-manager factions together and had sparked the organization of the Citizens Committee for Council-Manager Government.

At long last

In May of that year a complete slate of candidates, led by veteran Mayor White, faced the voters. Solidly behind them stood the League of Women Voters. Behind them were the informed citizens of San Antonio—no longer apathetic but sure of their cause. People like Rabbi David Jacobson; Mrs. Martha Johnson Zeck—indefatigable social hygiene

worker; Harold Kilpatrick—who got out a voter's guide for 25,000 churchgoers. Social Hygiene Day observances had spread the idea that a modern social outlook was a practical thing.

Behind them were the long years of work of the American Social Hygiene Association—with parents and police, military boards and professional agencies, with educators, lawyers and legislators. Genial Whitcomb Allen, ASHA's San Antonio representative, reviewed his backstage work over the years and wondered if it was enough to swing the election.

Paul M. Kinsie, head of ASHA's legal and social protection division, considered the election so crucial that he was on the scene to throw the weight of the association behind the reform movement.

Sensational was the impact of a \$1000 paid political ad prepared by Conroy, with help from Kinsie, that appeared in every San Antonio newspaper shortly before the election. This blast, aimed at every voter who opened a newspaper, told citizens the truth about prostitution conditions in the city and laid the responsibility for San Antonio's reputation as a "racket-ridden, wide-open town" on lack of law enforcement by the incumbent police commissioner.

When the votes were counted, the old commissioners threw in the towel.

"The ASHA ad clinched it," said Allen jubilantly. It was the first time in San Antonio's history that any candidate or group was willing to make an issue of the prostitution situation.

The police shake-up

Most spirited of the immediate reforms after this election was the crackdown on the police department.

The new councilman and police commissioner, Lt. Col. George W. Roper, veteran of Corregidor and a political neophyte, organized the department along the lines recommended by a survey conducted for the Public Administration Service by Dean O. W. Wilson of the School of Criminology of the University of California.

"Those who were doing their job (in the police force) got my backing," Roper said. "Those who didn't had to go."

Not to dictate, but to organize was his purpose. For a first-hand grasp of the prostitution problem, he rode around in police cars, was solicited himself by women of the street. In three weeks, from June 8 to June 30, 1951, San Antonio became a closed town.

The racketeers did not scurry for cover without offering a few protests. One night Roper's daughter picked up the phone to hear a voice—"If you don't stop these raids we'll take a shot at you." She did not hesitate to reply, "Sorry, but there are five or six ahead of you."



**A street-corner bar
is a silent reminder
of more roisterous days.**

One change Roper made in arrest procedures permits a policeman to make an on-the-spot arrest if he sees a violation. In the old days a policeman had to call the vice squad before making an arrest.

Roper put Lt. R. D. Allen in charge of the vice squad, and that officer lost no time in clamping down on the vice interests. "Captain Allen (he was made chief of police by Roper in November, 1951) would have resigned if I had not fought the racketeers," Roper explained.

On October 2 the new council-manager charter was adopted by a two-to-one majority, and in the following month the new nine-member City Council was elected. On January 1 City Manager C. A. Harrell, selected by these reform councilmen, took office—a \$30,000-a-year job—and said to his council, "I'll argue with you informally, but once the council has spoken, that will be the policy."

A new police chief

Texan-tall and quiet-spoken, Allen, who was reappointed chief of police by Harrell, reports that the closing of the district has cut down the number of murders and sex crimes, the cuttings, assaults and drunkenness once associated with prostitution activities. Even traffic fatalities have decreased from 53 in 1950 to 44 in 1951.

"Our population has increased in 10 years by almost 100,000 people, but our policemen are not so busy during the early hours of morning as they used to be."

Using a "stool" to get a prostitution arrest is not entrapment in San Antonio. Getting a conviction, however, is no easy matter, for it requires witnesses and proof of money paid. "Holding prostitutes, testing them—all this has a real nuisance value," says Allen.

"By attacking prostitution you make general police work easier," he adds. "Elimination of prostitution means elimination of much of the narcotics trade and many undesirable transients."

Alcohol does not flow freely

Taverns which once cornered a sizable portion of the vice business now eke out a modest profit from beer and wine sales under constant check by the police. No hard liquor can be sold legally in a tavern or eating establishment. Bulging hip pockets are *de rigueur* in the best night spots. But all alcoholic drinks do a Cinderella when midnight strikes, except in Saturday night's hour of grace.

Legitimate private clubs have lockers where members store their stocks of liquor. All kinds of bogus "private clubs" attempt this dodge and sell liquor after hours—until they're raided.

One tavern, ordered closed by the State Liquor Control Board on the recommendation of the police, remained open under an injunction. The police raided the place for operating as an open saloon and quarried over 300 patrons.

Using Col. Roper's file as a nucleus, the police now have a record for each of 2,500 establishments that sell beer and wine. Folders contain entries for every infraction. A separate card file shows when licenses are coming up for renewal. These files give the police all the information they need for making recommendations to the State Liquor Control Board for renewing or withholding licenses.

The vice squad's Sergeant Shaw points to an increase in prostitution arrests and reported gonorrhea infections during the new administration as proof that his squad is on its toes. "The higher figures are not evidence of worse conduct. They show vigorous police activity and enforcement," Sergeant Shaw emphasizes.

Out of a group of 418 women brought in, 30.6% were infected . . . 81 with gonorrhea, 47 with syphilis.

The military

Lt. Col. Albert Feldman, air provost marshal, of whom Col. Roper says, "He's doing a good job," is a young man of brisk, efficient manner. He handles an insistent telephone while he gives you a few pertinent facts. He tells you that when an off-limits restriction is slapped down on a tavern, the effect is catastrophic for that tavern. For San Antonio is dependent on the military. A tavern without servicemen is a tavern in the red—witness federal government payrolls of \$100,000,000 a year for the San Antonio area, with the military providing the major portion.

Of 28 places off-limits, 20 were put under this restriction because of prostitution activities. The reputation of an owner is a pivotal factor,

one hotel never having been on limits in two years because its owner is a bad risk.

Col. Feldman cites the good record of service personnel in the city, revealed in the comparatively small number of arrests of servicemen during December, 1951—only 476 out of the thousands of men in the area. At that, 210 of these arrests were for minor offenses. Parents need not fear when their sons are sent to San Antonio's military bases.

A few stories told by Feldman reveal the scarcity of prostitutes in the city. A panderer successfully tried one trick several times until a vice squad plant caught up with him. Approaching a group of soldiers, he would ask if they wanted a prostitute. In a "let's go" mood, they would climb into his car and drive off to the assignment.

"Give me your money for safekeeping and I'll give you a receipt," offered the obliging go-between.

When the soldiers reached the house, only an old man greeted them. The car and its driver were out of sight.

Another device was for B-girls (girls employed by taverns to wheedle soldiers into buying drinks) to hand out keys to soldiers in return for \$3. On one night 30 soldiers descended on a house, each with a key. The house was vacant.

Feldman says, "With the passing of prostitution and bootleg whiskey, legitimate business has improved and retail sales have increased. Taxes are now being paid that were never paid by prostitutes and their panders."

The rate should be zero

In tracking down VD contacts, military authorities cooperate with the health department and the police. If a soldier is infected, he describes the girl in a confidential report which is sent from the post hospital to the local health department. VD investigators may enlist the help of the police, who keep an arrest file and a picture file of prostitutes. On finding a likely suspect, the police send the photograph to the hospital for the soldier's identification. Even incomplete reports are valuable, one supplying the information another lacks, both sometimes pointing to the same source.

Col. Robert C. Gaskill, of the Fourth Army Surgeon's Office, says that a contact interviewer training school is being considered for the Army. "The contact index is not good. To combat VD successfully, we must find infected contacts and bring them to treatment. We don't have VD under control. Many of the contacts are never found and they multiply infections."

**Quadrangle,
Ft. Sam Houston.
The clock tower
was once a
watch tower.**



He quotes Col. E. O. Sandlin, Fourth Army provost marshal, who once said, "There is no acceptable VD rate. Any VD is bad. The rate should be zero."

San Antonio's VD rate is not yet zero, but the aim is on that target. Anyway you look at it, the city has done a herculean house-cleaning in six months' time. It is much further ahead than a Texas resort city whose chief of police was indicted for income tax evasion and whose mayor believes that everything should be available and a person should be taught to avoid what is harmful. Families are reluctant to live in an atmosphere so inimical to family life, and business is on the downgrade.

San Antonio is now engaged in a tax reassessment program. Expected additional municipal revenue from increased and equalized property values, as well as from new sources of revenue made possible by the new charter, will be used to finance an ambitious public works program and to establish a public welfare program.

The problem of crowded, outmoded housing, coupled with the high tuberculosis rate of San Antonio's Latin-American population, presents a serious challenge to the health department. Jack Mullen of the Chamber of Commerce is optimistic about the ability of the Latin-American to hurdle his difficulties. He says education is the answer. Perhaps he's

right—one public school which had a 10% Latin-American enrollment 10 years ago now has a 90% Latin-American enrollment.

A distinctive air

To Latin-Americans San Antonio is the United States. To others it is not typically American. Not quite western, not quite tropical, not quite south-of-the-border, it has a hybrid charm of its own. Its population, 406,811 in 1950, is compounded of Negroes (9%), Latin-Americans (40%), and leisurely Anglo-Americans. Not all the women are comfortably casual, not all the men are tall, topped by creamy, outsize Stetsons—but the impression is there, and it is enough to lift the spirits of the outsider, to make him sense the presence of the not-too-distant ranches and wide-open spaces.

The lobby of the Gunter Hotel is Wall Street, Texas style. There a cattleman can conclude fabulous deals as he relaxes in an easy chair. The high-speed, time-clock pace of New York is largely missing. Even a business interview may stretch into two, three, four hours, with no one concerned about the time.

Every 5-and-10 has its spoonful of chili sauce on a hot dog. Every restaurant has its Mexican dish. Even Mexican beer has a special quality all its own.

Nor was there ever a theater like the Arneson, straddling the river, its grass-covered seats on one side, its stage on the other.

Skyscrapers cut San Antonio's skyline, and wealth from oil, livestock, cotton, flax and citrus fruits flows into the city. Trade with Mexico and Central America centers here. New families are pouring in, sure of the bigness of San Antonio's future, of the integrity of its officials, of the wholesomeness of its environment.

For their efforts to better their government, the citizens of San Antonio well deserve the All-American City Award they recently won. Here is proof that an informed people can clean up the most entrenched corruption. Here is proof that the long-term diversified efforts of the American Social Hygiene Association to strengthen family life through education and effective law enforcement can have a paralyzing effect on vice. Here is proof, too, that other American cities, including Mexican border towns, however unregenerate, can shake themselves loose from their racket ties and "go and do likewise."

San Antonio will tell them it's worth the effort.



The Clinician and Syphilis Control

by Bruce Webster, M.D.

**A speech for Social Hygiene Day
in Los Angeles April 23, 1952**

During the last decade a non-toxic, readily administered agent—penicillin—has become available for the treatment of syphilis. It has simplified this treatment to an amazing degree and has revolutionized our concepts of the management of clinical syphilis. Eight years after its introduction it is important to examine the effect of this antibiotic on the control of syphilis in the United States.

For practical epidemiological purposes, syphilis is not one but two diseases. One of these, early syphilis (the first two years) represents an acute infection. The other, late syphilis, is a chronic disease of a crippling nature and represents a major public health problem.

Is syphilis declining in the United States since the advent of penicillin in 1943?

It would seem to the uninitiated that this would be a simple question to answer. As many of you know, it is now the subject of a heated controversy. An unqualified yes or no cannot be given to this question.

To attempt to answer it, one must consider not only the morbidity statistics concerning the increase of syphilis as a venereal disease, but one must take into account the amount of heart disease due to syphilis, the amount of central nervous system syphilis and many other factors. Due to the time lag in the development of these late manifestations, 15 to 20 years must elapse before the full impact of penicillin on these

factors can be determined. Further, it must be appreciated that in the five years prior to the introduction of penicillin, active syphilis control programs under federal and state sponsorship had been in effect.

- In 1949, it was estimated by the USPHS that 3,000,000 persons in the United States had syphilis.
- In 1951, 198,640 cases were reported by the various state health departments. This represents a consistent decline over the last five years.
- Approximately 14,000 cases of congenital syphilis occurred in 1949, although the infant mortality rate in that year was only one-fifth that of 1938.
- 13,000 individuals were known to have died of syphilis in 1949. This represents a 50% reduction in mortality from this disease in 10 years.

What does the physician have to offer the patient with syphilis at the present time?

The *patient* himself is primarily concerned with his chances of cure. The *community* is concerned with

- Reduction of infectivity
- Cleaning up of reservoirs of infection through epidemiological measures
- Prevention of late disabling complications which will become a drain on municipal funds.

Early, infectious syphilis

As a beginning, let us consider only early, infectious syphilis.

In 1945, 5,146 cases of infectious syphilis were reported in New York City. In 1949 only 2,218 cases were reported. Does this represent the true picture of the incidence of the disease? Probably not.

In 1945, arsenic and bismuth were still the mainstay of the treatment of syphilis in New York. Technical difficulties and the cost of administration sent most patients to a hospital or city clinic for their treatment. As a result, they were promptly reported to the city health department.

By 1949 the picture had changed greatly. Penicillin was readily available and was cheap. Further, it could be administered by any physician. Accordingly, syphilis became a disease which the neighborhood physician could treat himself. It was no longer necessary to refer it to a specialty clinic. Sometimes he was not too particular about diagnosis. After all, penicillin helped most venereal diseases. Similarly, either through lack of a consciousness of community health responsibility or in an effort to

"give his patient a break," he called it a "strain" or a "hair-cut" and did not report it to the health department.

How much of the apparent decline of infectious syphilis can be thus accounted for is impossible to determine.

In 1943, when Mahoney demonstrated the therapeutic value of penicillin in syphilis, a group of individuals set up a cooperative study to determine its effectiveness in terms of dosage and cure rates. Thirty-six institutions cooperated. A central committee distributed dosage schedules, and the results of follow-up were evaluated by a central biostatistical unit in Baltimore. As a result of this study—which, by the way, has established a model of procedure for other experimental therapeutic agents—ineffective dosage schedules were quickly detected and abandoned.

The experiment was terminated in 1949 and the analysis of results completed in 1951.

As a result of this study, eight years after the introduction of penicillin we are able to give to an individual patient with infectious syphilis a biostatistically sound estimate of his chances of cure with a given schedule of treatment. This is something we could not do for the arsenicals 30 years after the introduction of arsphenamine.

Certain aspects of this report are of fundamental interest:

- Up to a total dosage of 2.4 million units of penicillin an improvement in results followed an increase in dosage. There was no evidence that increase in dosage beyond this point served to reduce the failure rate.
- Durations of 4, 7.5 and 15 days showed similar results, other variables being equal. Below four days there was an increase in failure rate.
- Seronegative primary syphilis had the highest cure rate. High titre secondary syphilis, the lowest.
- Clinical relapse, if it occurred, took place within the first year. After that, evidence of "failure" meant infection.

With a penicillin dosage of 2.4 million units administered to infectious syphilis over an eight-day period, the cumulative failure rate due to clinical relapse and/or reinfection was nine per cent. An exact estimate of how many of these cases were reinfection is impossible to determine. On clinical and epidemiological evidence, several observers have estimated that 75% represent reinfection.

Thus it would appear that a patient with infectious syphilis, adequately treated with penicillin, has at least a 95% chance of cure, provided he does not get reinfected.



*14,000 cases of
congenital syphilis
occurred in 1949.*

Dosage schedules in early syphilis

Although the cooperative study on the penicillin treatment of early syphilis has shown that the optimum treatment schedule with the lowest failure rate is 2.4 million units over eight days, clinicians are constantly endeavoring to shorten the time-dose relationship. From a public health viewpoint, the ideal therapy is one which can be given at one visit.

There is pharmacologic evidence to support the idea of one massive dose as early as possible, since the spirochetes appear to be more vulnerable to such a concentration early in the disease. Two and four-tenths million units given in a single injection had a cumulative failure rate of 10% at the end of two and one-half years. The same amount of penicillin given in two doses four days apart had a failure rate of eight per cent. Given seven days apart, this rose to 19%. Thus it would seem that there must be a high concentration of penicillin maintained for approximately four days, either by repeated injection or a suitable action-delaying medium which may be in the offing.

The slow growth of the spirochete with a day-life of approximately 30 hours would seem to make apparent the fact that a single daily injection is adequate in any treatment schedule for syphilis, rather than the hourly or three-hourly regimes which were used formerly.

What of the five per cent failures? There is disagreement among authorities concerning the cause of these. Many feel that they all represent reinfections or superinfections. Whatever the cause, there is ample evidence that they can be retreated successfully with penicillin, either on the same or an increased dosage schedule.

Reinfection

Although reinfection in syphilis has been recognized for many years, the criteria for its diagnosis were formerly so rigid that it was rarely

made. Shortly after the introduction of the rapid treatment of syphilis with antibiotics, patients began presenting themselves—within a few weeks of the completion of treatment—with a new syphilitic lesion, usually in a different site from the previous one. Epidemiological investigation might reveal recent contact with infectious syphilis.

As these cases became more frequent, it became apparent that we were dealing with a reinfection and not a recurrence of the previous one. Was this apparently new phenomenon due to the fact that penicillin did not allow the individual to develop immunity, whereas the older, slower methods of therapy did?

The explanation is probably much simpler. Being infected with syphilis probably does not materially alter the sexual habits of the average individual. Accordingly, his exposure rate is the same before and after infection. However, with the older heavy metal treatment he returned to the clinic each week and received his weekly injection of arsenic, which acted, in reality, as a prophylaxis, destroying any spirochetes which he may have taken on during the week.

In addition to this, most clinicians now realize that in the past they labeled many cases recurrences which were reinfections. The differential diagnosis can only be made by combined clinical, serological and epidemiological evidence. Nevertheless, the principles of reinfection and superinfection have been established both in man and the experimental animal, not only in early but in late syphilis.

This phenomenon plays an important role in the evaluation of penicillin therapy. Does a second infection in a penicillin-treated individual represent a failure of the first treatment or is it an entirely new infection?

Prophylaxis

The problem of the penicillin prophylaxis of syphilis is one which is being forced on the attention of the clinician whether he be in private or public health practice.

With improved methods of contact investigation, it is not unusual for an apparently healthy individual to be notified by an investigator that he has been exposed to infectious syphilis. Schock has shown that if such individuals are given penicillin therapy they will not develop syphilis, whereas if they are allowed to go untreated at least 60% will show evidence of infection. Further, they may infect others before they are brought under therapy. The fact is now well established that relatively small amounts of penicillin will destroy the spirochetes in this preclinical invasion stage. Despite certain obvious disadvantages from a sociological viewpoint, it would seem that a conscientious physician would find it difficult to refuse such an individual treatment.



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Bruce Peck Webster, M.D.

To go one step further, there is the problem of the individual who thinks he may have been exposed to infectious syphilis and presents himself to his doctor the next day asking for prophylactic penicillin. What is to be done about this individual? At the present time opinion is divided among conservative physicians as to whether or not he should receive prophylactic treatment. However, if he does not receive it from his own physician there is always the less conscientious one from whom it can be obtained. If such an individual is treated, it should be done on the unconditional promise that he will submit to serologic follow-up for at least six months.

The dosage of penicillin required for such prophylactic treatment is at present the subject of investigation by various individuals. The newest action-delaying forms of penicillin offer much hope in this regard.

Impact of penicillin on late syphilis

As was stated earlier, syphilis is in reality two diseases, an early infectious one and a later one with crippling systemic manifestations.

In between these two stages, there is the period of *latent syphilis*, which is fundamentally a public health problem. Manifesting itself as it does only by a positive serologic test for syphilis, it is detected only when such a test is taken. If it is not detected, at least 15% will develop serious manifestations of the disease sometime later in life.

Although the United States has the most extensive case-finding mechanisms in the world, undetected latent syphilis is still a major problem. It is estimated that 80,000 cases go undetected annually. The masking of early syphilis by the penicillin treatment of gonorrhea without adequate serologic follow-up may further increase this number.

If we are to prevent the development of cardiovascular or central nervous system syphilis—and we *can* prevent it by the adequate treatment of latent syphilis—we must continue and increase our case-finding through premarital, preemployment and the various other means of serologic testing. In this connection, perhaps we have neglected the education of the family doctor. He should be encouraged to perform a serologic test for syphilis

on every new patient and at regular intervals on his old ones. Every hospital or clinic admission should include such a test.

Only by such nation-wide extensions of our serologic testing can latent syphilis be detected.

What can we do about latent syphilis once it is discovered? The first step is to establish the fact that the disease is latent. A careful physical examination including a chest x-ray and spinal fluid examination must be done before the patient can be told that his disease is still latent.

Our knowledge of the effect of penicillin treatment in latent syphilis is largely by analogy of what we know it will do in early and in central nervous system syphilis. This is supplemented by reports of the treatment of early latent syphilis in which from 50% to 60% of the cases became seronegative or had appreciable drops in titre following treatment. The remainder, as would be expected, remained seroresistant. The minimal dosage of penicillin for the treatment of latent syphilis would seem to be four million units given over a period of 12 to 14 days. In the light of our present knowledge, such a schedule should protect the patient with latent syphilis against the development of central nervous system or cardiovascular involvement.

Central nervous system syphilis

In 1943 the skeptics felt that penicillin offered little to the patient with central nervous system syphilis. By 1946 there was general agreement that it would accomplish as much as heavy metal therapy and in a much shorter time. However, there were still many advocates of concurrent fever treatment.

Gradually the confusion has cleared and there is almost universal agreement that four million or more units of penicillin given over 14 days is adequate treatment for asymptomatic neurosyphilis, acute syphilitic meningitis and meningovascular syphilis. There are still a few who maintain that the degenerative forms of the disease—tabes, paresis and primary optic atrophy—require concurrent penicillin and malaria therapy. It would seem, however, that there is mounting evidence to indicate that penicillin alone is adequate in these forms of the disease.

Too much stress cannot be placed on the early diagnosis of central nervous system syphilis. Every patient in whom a diagnosis of late or latent syphilis is made should have a spinal fluid examination. The detection and treatment of asymptomatic central nervous system syphilis will completely eradicate tabes, paresis and primary optic atrophy, thereby relieving the taxpayer of the burden of support of these people.

In this connection, I am reminded of an historical fact. Late in the 15th century the city of Frankfort offered free treatment with mercury to persons with syphilis and, as an inducement, made them tax-exempt

during the treatment period. Such a case-finding method might prove valuable today.

Cardiovascular syphilis

Approximately 15% of all early syphilitics, if untreated, will develop cardiovascular lesions. Although it is to be hoped that with the adequate therapy of early syphilis and the detection and treatment of latent syphilis there will be a decrease in the amount of this form of the disease, it is likely to be a sizable public health problem for some time to come.

The detection of early cardiovascular syphilis in any clinic is in direct ratio to the training and interest of the physicians in that clinic. Every late syphilitic should have a careful physical examination and chest x-ray. The aim should be the detection of early, uncomplicated aortitis before it has gone on to aortic insufficiency or aneurysm.

Once the disease is detected, the patient should receive not only specific treatment for his syphilis, but should be evaluated as any other cardiac patient in terms of workload and his cardiac reserve. Here the social worker and public health nurse are indispensable.

Recent studies have shown that specific penicillin therapy brings about a change in the aorta, rendering the syphilitic process inactive. A biostatistical analysis of 1,200 cases of syphilitic aortic insufficiency from Johns Hopkins and the New York Hospital is now in progress in an effort to determine the natural history of the disease. It is already apparent that the adequately treated, properly managed patient with uncomplicated aortitis or syphilitic aortic insufficiency, even after the onset of failure, has a much better chance of survival than was formerly believed.

The teaching of syphilis

Fifteen years ago a prominent authority on syphilis was accustomed to tell his students in medical school that the diagnosis and treatment of syphilis was a complicated procedure requiring the facilities and the knowledge of a specialist and that they had best refer their patients to him. Thus he disposed of the treatment of syphilis.

Ridiculous as such a statement was, it was not without truth. The administration of old arsphenamine was not to be undertaken lightly. Accordingly, the average physician did refer such cases to a clinic or to the specialist.

With the introduction of penicillin therapy, this picture has changed. Any doctor can administer it with safety. A marked decrease in the cases of syphilis reporting to clinics has resulted. This can only mean that the general practitioner is treating the disease in his office, and this is as it should be. Such a broadening of the base of treatment

sources is bound to result in increased control. However, it places a serious obligation on medical schools and federal, state and county venereal disease control agencies.

If every physician is to treat syphilis, he must be familiar with the latest information, both in diagnosis and treatment.

To equip the undergraduate physician with this knowledge is the responsibility of the medical schools. How to do this in the face of rapidly decreasing clinical material is a problem of some concern to many of us. However, it is obvious that, more than ever before, the medical student must be equipped to control syphilis.

The education of the physician who is already practicing is the problem of the various echelons of the health department. Renewed efforts must be made to make physicians syphilis-conscious. They must be provided with facilities for the darkfield and serodiagnosis of syphilis. They must be acquainted with current treatment schedules and educated in contact investigation and follow-up.

The patient, by seeking the aid of such physicians, has enrolled them in the cause of syphilis control. It is up to health agencies to welcome them into the ranks and equip them to do their job if necessary.

Conclusion

I have attempted to outline the common problems in the control of syphilis which confront the clinician, whether he be in private or public health practice. Coincidentally, one must consider the impact of penicillin on the management of these problems.

In only two decades in the history of mankind has syphilis been dealt a severe blow. The first was the period between 1905 and 1910 during which the spirochete was isolated, the Wassermann reaction developed and arsphenamine introduced. The second was the present one in which penicillin was introduced as a safe, rapid form of therapy. One must not neglect to mention, in addition, the strides which have been made in case-finding and the early diagnosis of late forms of the disease during the last 10 years.

What does the future hold? The indications are that we can expect more, and perhaps more powerful, antibiotics or improved action-delaying media, so that the dream of a single injection treatment may not be too far removed. The cultivation of the spirochete and possible immunization to it is still more remote. In the meantime, it behooves us to continue our efforts at control for the sake of this and future generations.



JUMPING JURISDICTIONAL LINES

Case-finding steps outside the state

by Adele C. Shepard, M.D.

New Jersey has been successful in lowering its syphilis incidence rates, and it is now in the lower half among the states in attack rates per 100,000 population. To maintain and improve this control, however, more concentrated activity is necessary. The present nation-wide defense program has caused a significant dislocation of population in the state, and there has been a sharp increase in the number of young people separated from their home influences.

In addition to being highly industrialized (New Jersey has more factory workers per square mile than any other industrial state), the state has the largest concentration of military personnel on the eastern seaboard, and even greater concentrations are anticipated. The migrant agricultural labor force in the state constitutes a roving population in excess of 50,000 annually. Moreover, there are hundreds of thousands of transient workers and visitors associated with the numerous resorts and seaside recreational areas.

Military-civilian exchange of data

As early as November of 1948, the Army, Navy and Air Force, Coast Guard, Public Health Service and Association of State and Territorial Health Officers reviewed previous agreements and again expressed their interest in an agreement for the control of venereal diseases.

These organizations were particularly concerned about problems of prevention and control created by the anticipated increase in Armed Forces personnel and by the mounting number of individuals entering defense industries. The necessity for collecting and exchanging information about civilian contacts of infected military personnel and military contacts of

civilians with venereal disease infections was reemphasized in this agreement. It was hoped in this manner to bring to treatment more quickly those contacts who needed treatment.

Early case-finding by investigation of contacts is the most important aspect of the venereal disease control program. Until we can break the case-contact-case chain, infections continue to be spread in an ever-widening circle.

Contact investigation is increasingly difficult under circumstances such as exist in New Jersey today where the nature of the venereal disease contact generally is quite different from the contact during periods of population stability. The encounter today is frequently a chance meeting with little, if any, exchange of personal information between sexual partners. Any information which may be given is often fictitious, because the type of person named as a pick-up or prostitute prefers to remain anonymous. A soldier on leave in a strange city may not even remember the name or location of the bar where he met his pick-up.

The usual methods of interviewing, investigation and routine channeling of venereal disease contact information are inadequate to cope with this problem of incomplete information about transient contacts and suspects.

Federal assistance

Recognizing the dangers and difficulties inherent in such a situation, the New Jersey State Health Department—beginning in July of 1951—obtained federal assistance in the development of a project aimed at maintaining an adequate venereal disease case-finding program.

The plan was to assign trained interviewer-investigators to military installations and recreation areas frequented by military personnel. They were to be given authority to work with both civilian and military populations, since the control problems of the two groups are closely interrelated.

New Jersey's Bureau of Venereal Disease Control and the United States Public Health Service screened approximately 60 applicants to fill the five

*New Jersey—a mecca
for industrial workers.*



positions in the program. Of the men chosen, one was an experienced Public Health Service employee transferred from another area, and four were trainees. All had college degrees, a prerequisite for the positions. Men were selected because it was felt that male investigators were preferable for locating contacts under the circumstances noted above.

Special training

Orientation of the investigators began in the state health department, where they learned about the organization and program of the department—the various divisions and bureaus and the nature of their work, the functions of district health offices and local health departments, and the relationships of these groups to each other.

The four trainees received instruction in the principles, history and development of venereal disease control, in the medical and public health aspects of the problem, and in the purposes and interpretation of records and reports. Another important part of their instruction dealt with public relations, a vital aspect of this program where the investigators were to be in contact with various health departments, military establishments, private physicians, community organizations and the general public.

Upon completion of this orientation program, the men were sent for courses in interviewing techniques to schools designed for this purpose and located in Alto, Ga., and in Norfolk, Va. When they returned to New Jersey they were given field training in investigative techniques by a person with considerable experience and skill in the application of these techniques.

Only then did the Bureau of Venereal Disease Control feel that they were ready for field assignment.

By September of 1951 the men were ready for duty and were assigned to five areas in the state which had expressed a need for the assistance these men were prepared to render. Requests were based on an appraisal



*They learned
the answers
to VD control.*



*M.D. degree from Northwestern.
M.P.H. degree from Columbia.
Chief, VD Control Program,
N. J. State Department of Health.*

Adele C. Shepard, M.D.

of their real and potential venereal disease case-finding problems. The five investigators were assigned by the bureau through district health offices to Newark, Camden, Atlantic City, Camp Kilmer, Fort Monmouth, and their surrounding areas, and each became, in effect, a local health department worker . . . with one major difference.

Crossing jurisdictional lines

Agreements were made with the responsible authorities in the military installations, in the health departments of New York City and Philadelphia, and in various municipal health departments in New Jersey whereby the investigators were permitted to cross jurisdictional lines to obtain more complete contact information from military personnel and to locate out-of-state civilian contacts as well as suspects in other areas of New Jersey.

The health authorities, of course, were to be informed of all investigative activity in progress in their territories. Such coverage of localities outside the assigned area had been used to a limited degree in earlier control programs but was extended significantly in the present study.

Crossing of jurisdictional lines may involve obtaining the permission of the commanding officer at a military base to allow an infected soldier to accompany the investigator to another area to trace a contact. Fort Dix, a large army post near Trenton, had sufficient personnel so that the assignment of a man from the health department investigative staff was not necessary, but a close working relationship was established between the bureau and the post's preventive medicine officer.

From Fort Dix to Philadelphia

As an example, the health program representative of the Public Health Service attached to the New Jersey State Department of Health was requested to reinterview an enlisted man at Fort Dix who had given fictitious information about his contacts. The soldier vaguely described two exposures in a house of prostitution "somewhere in Philadelphia," but he could not give the address.

Permission to transport the soldier to Philadelphia was granted, and the New Jersey investigator arranged to meet with the senior investigator



New Jersey — center for service personnel.

of Philadelphia. The soldier was taken to the bus terminal near Broad and Market, the place at which he had entered the city on his previous visit. The route taken by the GI was retraced from that point. Some 50 blocks and 30 minutes later he identified the house where his exposures had occurred.

Six prostitutes were found in this establishment and all were examined in Philadelphia clinics. Their infections totaled six cases of gonorrhea, one case of chancroid and two cases of previously treated syphilis.

A similar incident involved a corporal stationed at Camp Kilmer who was diagnosed as having infectious syphilis. He knew his contact by her first name only, but was permitted to accompany the investigator to a Times Square bar where he had met the girl. Fortunately, she appeared and the soldier pointed her out to the investigator, who was then able to obtain her full name and address. Arrangements were made for her to attend a New York City clinic the next morning.

Their interviews are productive

On the first day of his assignment to Fort Monmouth the health department investigator was requested by the physician in the station hospital to reinterview an enlisted man who had given no usable information

about his sexual contacts. More than an hour later he terminated his interview with the soldier. Net result—eight sexual contacts not previously given were named and described.

In addition to his activities at the military installation, this investigator also works in a number of venereal disease clinics in Monmouth County. For many years the county had been making a substantial appropriation for venereal disease control, but, believing that the program was no longer needed, it had eliminated the amount required for this program from its latest budget plan. After existing local problems were pointed out, however, by the intensive case-finding activity on the part of the investigator assigned to this area, the appropriation was restored.

Atlantic City, New Jersey's renowned resort, also proved to be a fertile field for case-finding. The investigator serving this locality immediately began operations through the city's venereal disease clinic. It was critically understaffed and averaged only about 50 clinic patients per month.

After four months of intensive case-finding, the monthly clinic attendance reached the 300 mark. Plans are now under way to integrate the venereal disease clinic with the outpatient services of the Atlantic City Hospital so that more adequate diagnostic and treatment services will be available.

Preliminary results are promising

Complete evaluation of performance by the investigators will not be available for some months. Monthly evaluation of investigative activity indicates, however, that approximately 76% of the suspects investigated were brought to examination. This percentage is well above ordinary expectations. Of 595 individuals examined, 271 needed treatment. These results are gratifying.

It is my feeling that our selected college-trained investigators have achieved outstanding success in the location of individuals suspected of having venereal disease, thereby increasing the number of infections detected. They have established effective working relationships between military and civilian venereal disease programs and have provided, in addition, valuable assistance to local health departments.

Six months have elapsed since the beginning of active field duty in this new military-civilian effort in venereal disease control in New Jersey. Statements regarding results to date, therefore, can be considered in the nature of a preliminary report only, but we believe the project gives sufficient promise of future success to warrant its continuing expansion.

Great hope is placed upon this case-finding approach to keep the New Jersey venereal disease attack rate at its present low level during this period of military and industrial mobilization.

To Ernest Boyd MacNaughton



Engineer, pioneer builder and organizer, financier,
civic leader, educator, patron of the arts, philanthropist

Who as a young man was one of a courageous group
that pioneered the social hygiene movement in Oregon

Who from his great store of knowledge of men and
affairs wisely counseled our leaders

Who led his fellow citizens in generous support of our
Association

Who strengthened the national social hygiene move-
ment by serving as our vice-president

The American Social Hygiene Association is proud
to award in 1952

WILLIAM FREEMAN SNOW AWARD
FOR DISTINGUISHED SERVICE TO HUMANITY

Mr. MacNaughton's Acceptance

Why was I chosen to receive the William Freeman Snow Medal for distinguished service to humanity? In other years men and women of such eminence as General Pershing, Dr. Ray Lyman Wilbur and Sir Sidney West Harris have received the Snow medal. I think the American Social Hygiene Association decided to award the medal to me because it wanted, through me, to pay tribute to the west coast's pioneering work in the social hygiene field.

In naming me the 1952 Snow medalist, the Association is undoubtedly thinking of me as a symbol of all those hundreds of people of the west coast who have contributed over the years to the control of social disorders and to the growth of education for family life, marriage and parenthood.

In the 40 years since the inception of the social hygiene movement, we people of the west coast have come far in this field. We insist that young men and women have blood tests before we permit them to marry and establish families. Through our homes and our churches, our youth groups and schools, we try to prepare young people for the joys and responsibilities of successful marriage and happy parenthood.

We have not yet finished our social hygiene job here on the west coast. There are still things to do. We still must convince many people that penicillin is not the final answer. Penicillin cures . . . but it doesn't find disease. Penicillin cures . . . but it doesn't prevent the misconduct which transmits disease. We can't substitute medicine for morals.

If you could give your son or daughter only one gift for a happy life, what would it be? Money? Brains? Good looks? Character? The thoughtful parent would certainly say character.

This, then, is the big aim of the social hygiene movement . . . to help parents, teachers, ministers and others who guide young people to give our youngsters that precious gift, that priceless heritage . . . clean blood and good character.



Newell Walter Edson

HONORARY LIFE MEMBERSHIP

1952

A New Englander by birth and inclination, Newell Edson well exemplifies the views of another son of the rockbound coast who said in *The Education of Henry Adams*, "a teacher affects eternity; he can never tell where his influence stops."

Although for 30 years Mr. Edson has borne officially such labels as "welfare worker," "social hygiene field representative" and "social hygiene executive" and has well fulfilled the tasks concerned, he is essentially and forever in the ranks of those who "gladly learn and teach" and his works go marching on.

His influence through his writings, his lectures for students, teachers and parents, his personal-guidance conferences and his citizenship can hardly be measured in set terms. Rather, these efforts are like pebbles dropped in a pool whose borders are without limit and whose ripples will continue to spread as long as people seek for the help social hygiene can give.

Newell Edson was set in the "learn and teach" pattern some years before he found the social hygiene field henceforth his pasture. Born in Portland, Me., in 1881, he attended public schools there, then entered Harvard College, graduating with a B.A. in 1903. For two years he was English instructor at the University of Maine, and then for 16 years served as teacher and principal in various well-known boys' schools such as the Hill School, Pottstown, Pa., the Huntington School, Boston, and the McBurney School, New York City.

During this time he studied at Harvard, Yale and Columbia, specializing in education and psychology.

In 1920 he became an educational assistant in the U. S. Public Health Service's venereal disease division and a new future began to open which promised to utilize all his previous training and experience. In 1921 he joined the staff of the American Social Hygiene Association to work in the new Division of Educational Measures. Since that time, except for a brief period of social service, Mr. Edson has been counted among the country's most active social hygiene workers.

At the time Mr. Edson came to ASHA, the organization was just swinging into its broad postwar program. The Division of Educational Measures was breaking ground towards the long-range objectives then stated as an essential part of the "four-fold American plan" and today recognized as the underlying foundation for all social hygiene progress. The measures proposed sought

"to provide sound character-training in childhood and youth, as a major influence in the promotion of high moral standards of sex conduct; to furnish accurate and suitable sex instruction as a part of human relations education and of training for marriage and parenthood."

Under the direction of Dr. William F. Snow and Dr. Max J. Exner, with the guidance of Dr. Thomas W. Galloway and Mrs. Anna Garlin Spencer, Mr. Edson was soon busy with training courses for teachers, institutes and lecture courses for parents, students and the general public, and writings for all these audiences. For 11 years he was chairman of the National Congress of Parents and Teachers' social hygiene committee, conducting conferences at seven national and some 30 state PTA conventions.

He has given courses in important American colleges and universities in nearly every state, discussing such topics as "The Theory and Practice of Sex Education"; "Social Hygiene and Sex Education"; "Education for Marriage and Parenthood" and "Education for Marriage and Family Life."

Out of his experience with such audiences and particularly from his expert handling of the lively question periods which invariably follow his talks, Mr. Edson has come to know well the kind of information and guidance wanted and needed by the public, especially by young people. A number of enduringly useful and popular pamphlets—many of these have been published by ASHA—have resulted. Among them are *From Boy to Man*, for adolescent boys; *Love in the Making*, a talk for older boys, and *Choosing a Home Partner*, for young men and women.

He is also the author of several publications used widely by professional social hygiene workers, such as "The Status of Sex Education in

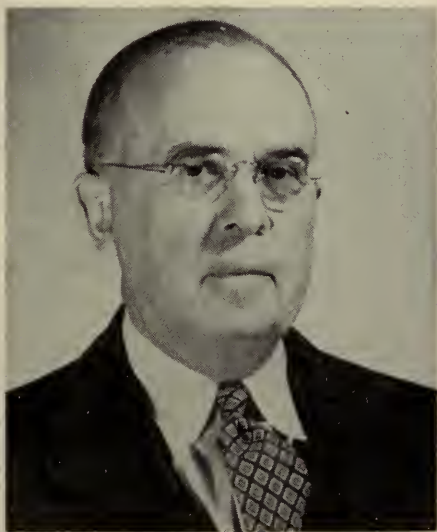
High Schools"; "Cooperation of Home and School in Guiding Boy-Girl Conduct" and "Discussion Outlines on Love, Courtship and Marriage." He has often contributed to educational magazines.

From 1932 to 1934 Mr. Edson was director of ASHA's division of education and family relationships. Shortly after this, when it appeared that ASHA's main effort was needed to back up Surgeon General Parran's nation-wide drive against syphilis, Mr. Edson served as field representative for ASHA's National Anti-Syphilis Committee.

In 1938 he became executive secretary of the Erie (Pa.) Social Hygiene Association.

Like most successful executives Mr. Edson owes much of that success to a steadily cooperative and understanding helpmate. Shortly after his graduation from Harvard he married Miss Jennie Ethylyn Boody of Portland, Me., alumna of Massachusetts Normal Art School and instructor of art in Framingham (Mass.) State Teachers College. They have one son, Dr. John N. Edson, practicing cardiologist in Brooklyn, N. Y., and two grandchildren, John Richard and Joanne Newell.

It is a satisfaction and pleasure to the Committee on Awards to confer this Honorary Life Membership upon Newell Walter Edson, a social hygiene pioneer of valuable and lasting attainments.



John Hall

HONORARY LIFE MEMBERSHIP

• 1952

"One of the rollingest stones that ever bounced along the public health highway," John Hall says of himself. Others call him "Honest John" or "Johnny-on-the-Spot."

For the American Social Hygiene Association he has done more jobs in more places than any of us. More times than even he can remember he has resigned and retired. His most recent "final" retirement occurred last fall after a strenuous summer as an ASHA field representative. No one will be surprised, however, to hear that he has just returned from Alaska, where he went on a social hygiene mission of special importance to national defense.

John Hall was born in the old village of Freehold, N. J., which he still calls home. Following 1912 when he received a degree in sanitary engineering from the Massachusetts Institute of Technology, he worked with the state health departments of Massachusetts, Maryland and his home state.

He married Lillie Worden on April 24, 1915, and one child, a daughter, was born to them. Mr. Hall and his wife have three grandchildren, one brand new. This situation, he says, calls for full utilization of all his social hygiene experience.

World War I saw Mr. Hall an Army Sanitary Corps captain in France, where after the Armistice he studied at the Sorbonne and gave the Republic a thorough inspection. Business experience came next—as purchasing agent for a New York cloth concern, as salesman for a chemical company, as cashier in his hometown bank, and as an architect and builder there.

But interest in public service and a flair for propaganda soon brought him back to the public health field. As editor and promoter of a Health Bulletin Service initiated by the American Public Health Association and later taken over by the New Jersey Health and Sanitary Association—of which he is long-time secretary—Mr. Hall pioneered in the production and distribution of simple, readable articles on many phases of public health. Published in the NJH&SA's *Health Progress* and subsidized as a health education experiment by the New Jersey State Board of Health, these texts were used widely by local health departments and health workers.

Mr. Hall's interest in social hygiene started in 1916 when as health officer of East Orange, N. J., he became a member of the Oranges' VD Control Committee. This organization, the clinic it operated and the public information materials it produced were models for similar efforts 20 years later.

New Jersey's health department kept its VD control division intact through the postwar years and when the 1936 upsurge of VD activity started, the New Jersey program was promptly stepped up and John Hall was called in. His flair for public education was put to use, and the posters and pamphlets he prepared and meetings he helped to promote got favorable mention across the country.

At the same time he was calling the attention of professional workers to New Jersey's program by articles in the JOURNAL OF SOCIAL HYGIENE.

World War II saw Mr. Hall offering his services where they might be of most value. The U. S. Public Health Service placed him in charge of sanitation for Nevada's important Las Vegas area. Later he spent a year in similar work for Alaska's health department.

He left Alaska to join ASHA's staff, which since 1939 had been doing its part to build military and industrial health and morale by providing VD educational materials for the Army and Navy and by stimulating communities to provide clean community conditions for servicemen and defense workers.

Clean-ups and cross-country tours

The important job of cleaning out prostitution nests near military areas—many of them strongly entrenched and preying on soldiers and sailors—challenged Mr. Hall and he joined the ASHA field staff, first in the southwest, then in the middle-eastern states and later in eight far west states. His aggressive and conscientious work brought about improvements in strategic areas.

A postwar barnstorming tour of important cities by top VD and Social Protection officials plus Mr. Hall—which reached large gatherings of municipal authorities and citizens—apparently clinched wartime gains. Six years later frequent surveys of these formerly wide-open cities find them—with very few exceptions—practically free from commercialized prostitution. Mr. Hall retired from these activities in 1946.

When mobilization began in 1948 and the Defense Department and Public Health Service again needed ASHA's aid, "Johnny-on-the-Spot" came out of retirement to serve as ASHA's director of field services, to recruit and train a new field staff and to re-establish needed services in seven field offices across the country.

Although Mr. Hall has retired from ASHA's full-time permanent staff, he has made himself available for special emergency assignments of the kind which recently took him to Alaska.

Between hither and yon assignments, Mr. Hall edits the New Jersey Health Officers Association's *News Letter*, helps to promote legislation for improved local health administration in New Jersey, and serves as president of the Freehold YMCA board.

He likes to putter around his garden in the summer and to build things in the winter, specializing in flowers, brick fireplaces for backyards, high-class indoor painting and carpentry. He claims to be the slowest—but not the worst—mechanic in the world.

Mr. Hall's contributions to the American Social Hygiene Association and through it to the health and welfare of the nation have been singularly diverse and practical. The Association is proud to include him among its distinguished group of Honorary Life Members.

Chauncey D. Leake



HONORARY LIFE MEMBERSHIP

1952

As a trail blazer for modern progress in the field of science, Chauncey D. Leake, Litt. B., M.S., Ph. D., educator and medical school administrator, has a breadth and depth of mind that can encompass today's detail and tomorrow's distant goal.

His courtly manner and soft tone of voice belie the aggressiveness with which he cuts through red tape to achieve dynamic results, or the vigorous leadership he gives to his work—whether it is in the meticulous realm of research, in the clarification of social and medical ills, in remedial programs, or in the challenging area of human relations.

Born in Elizabeth, N. J., on September 5, 1896, Dr. Leake early evidenced his interest in science. With degrees from Princeton and the University of Wisconsin, he became an instructor in physiology and pharmacology, spent some time in the Chemical Warfare Service of the U. S. Government in World War I, and in 1928 went to the University of California to organize the department of pharmacology. From there he went in 1942 to the University of Texas as executive vice-president in charge of the medical branch at Galveston.

The record of Dr. Leake's service to humanity is long and varied and includes a wealth of honors:

- as a teacher of pharmacology and the history of science and medicine,
- as a research authority whose contribution to the knowledge of blood production and anesthesia resulted in new inhalation anesthetics and a special award from the International Anesthesia Research Society,
- as a translator of medical classics such as *De Motu Cordis*,
- as an administrator of a pharmacology laboratory which became the training center for pharmacologists and toxicologists,
- as a scientist whose findings protected industrial workers from poisonous new chemicals,
- as a speaker, editor, and writer on medical ethics,
- as an advocate of new drug treatments for amebic dysentery.

In all of these things Chauncey Leake excels.

He has given his inspiration to innumerable offices and to his students, both collectively and individually. He has served as president of the History of Science Society and as chairman of the American Medical Association Section on Pharmacology and Therapeutics. He originated the Family Relations Center of San Francisco and promoted the Planning Commission of that city.

He organized venereal disease control efforts throughout the State of Texas, set up the University of California course on family and human relations, lectured at many universities and colleges, served as honorary consultant to the Army Medical Library and gave invaluable direction to the University of California Medical Library.

Perhaps no more fearless stand against prostitution and related vice has been waged anywhere than in Galveston, where citizens without the support of Dr. Leake's authoritative voice would have feared to take a stand against the entrenched forces of crime. As one facet of the promotion of public health in Texas, Dr. Leake advocates abolishment of segregated districts and suppression of commercialized prostitution, which contributes to the incidence of communicable social diseases.

A singularly erudite and personable individual, he has a diversity of interests that never flag, ranging from enthusiasm for dramatic lighting and public speaking to the serious promotion of the Hoover Commission Report.

In all of his endeavors for the furtherance of science and betterment of human relations, Dr. Leake has had the understanding encouragement of

his wife, formerly Elizabeth Nancy Wilson, whom he married in 1921. They have two sons, Chauncey and William Walker.

The lengthy recording of honors bestowed upon this man of science reveals him to be a man of intellect and vision, of breadth of learning and purposefulness in action.

The Committee on Awards of the American Social Hygiene Association considers it a privilege to acknowledge the contribution of Chauncey D. Leake to the health and welfare of our country by conferring upon him an Honorary Life Membership for his work in social hygiene.



Paul J. Zentay, M.D.

HONORARY LIFE MEMBERSHIP



1952

Dr. Paul J. Zentay's whole career, whether in private practice or public service, has been strongly affected by his concern with the social aspect of medicine. He has been a teacher, a medical relief official and a public health officer. Since 1934 he has been an officer of the Missouri Social Hygiene Association and actively involved in the development of its program.

Dr. Zentay was born in 1891 in Kozsna, Hungary, the son of a practicing physician. After completing his general education he studied medicine at the University of Kolozsvar in Hungary.

He graduated from medical school in August, 1914, the first month of World War I. He was called into the Austro-Hungarian army and spent 46 of his 52 months of service at the front.

After the war he became attached to the University of Budapest and served one year in the Department of Pathology and three years in the Department of Pediatrics, where he was director of the laboratories.

His next move was to determine the direction of the rest of his life. In 1921 he accepted appointment as medical director of the American Red Cross in Hungary and organized the child health program there. This work was described—in the final report of the American Red Cross Commission for Europe—as an outstandingly successful project. It also led to his appointment as medical director of the American Red Cross commission on relief for refugees in Greece.

In the latter part of 1923 Dr. Zentay came to the United States, where he worked in the Maryland Department of Health's bureau of child hygiene under Dr. J. H. Mason Knox.

At the invitation of Dr. McKim Marriott, Dr. Zentay came to St. Louis in 1924 to join the faculty of Washington University Medical School. For two years he was a member of the full-time teaching staff as an instructor in pediatrics. In 1926 he changed his status to that of part-time instructor in order to engage in the private practice of pediatrics. Later on, in 1948, he was promoted to assistant professor of clinical pediatrics.

Earlier, in 1933-34, he had interrupted his private practice to take the post of assistant health commissioner for St. Louis. During his term of office an epidemic of encephalitis broke out, known since then as the St. Louis type of that disease. He directed with conspicuous and widely acknowledged success the public health and organizational work made necessary by this crisis.

Diverse activities

The work of a public and social nature carried on concurrently with his private practice has included, among other things, the activities of the St. Louis Pediatric Society's medical milk commission. He was secretary of the commission from 1926 until it ceased operations. In 1933 he was also president of the American Association of Medical Milk Commissions.

Dr. Zentay is the founder and a past president of the Planned Parenthood Association of St. Louis, a member of the board of the Tuberculosis Society, a member of the board of the International Institute, past president of the Public Question Club and past chairman of the Civil Liberties Committee.

In June of 1934 the board of the Missouri Social Hygiene Association elected Dr. Zentay president, the position he held until 1938 when he

became vice-president. He served in this capacity until 1949 when he was again elected president, the post in which he has remained.

During his tenure of these offices a number of important developments have taken place in the field of social hygiene.

Through Dr. Zentay's initiative the St. Louis Health Division's venereal disease control service was modernized and reorganized.

Under his leadership the prenatal blood test bill was enacted by the Missouri legislature. Through this measure the incidence of congenital syphilis has been reduced.

He also was a leader in the fight for enactment of the premarital blood test bill. The educational value of this act has been very great.

Social hygiene teaching in the St. Louis schools was inaugurated by the Board of Education upon the urging of a Missouri Social Hygiene Association committee headed by Dr. Zentay. The first lectures on social hygiene to high school students were delivered by him. After a period of demonstration for two years by the Social Hygiene Association the plan was taken over by the Board of Education and at present is being continued in a greatly expanded form.

The "area project" of the Missouri Social Hygiene Association, which drew nation-wide attention, was initiated upon the advice of Dr. Zentay, who believes that any educational message must be taken to the people in their own neighborhood and that for success their initiative and interest must be enlisted.

During the last 19 years almost any progress made by the Missouri Social Hygiene Association is in some manner and degree connected with the activities of Dr. Zentay.

He is a member of the pediatric staff of the St. Louis Children's Hospital and of the Jewish Hospital, is pediatrician and neurologist of the Shriners' Hospital for Crippled Children, and chief of pediatrics of the Labor Health Institute. Besides his connection with the Department of Pediatrics, he also holds an appointment as instructor in clinical neurology at the Washington University Medical School.

He is married to Elizabeth Grayson and has two sons, John, who is a junior at Harvard, and Peter, who is a senior at John Burroughs School.

To Dr. Paul J. Zentay, in grateful recognition of his valued leadership and many contributions to social hygiene, the American Social Hygiene Association is proud and happy to award an Honorary Life Membership, with the hope that he will long continue to share with us his experienced wisdom.

THE LAST WORD

I personally always had the strong feeling that anybody who is trying to render any kind of public service should not expect and should not even hope for any kind of gratitude or any form of recognition. The work he does carries in itself its rewards; it gives enough satisfaction in the spiritual sense, even though results may not be measured in immediate achievements. Besides, the important point is doing good work for your community even if it is done anonymously, as it is not important where the credit goes as long as the work is done and the community is benefited.

It has been my credo that a man, and certainly a physician, owes much more to the community than just to make a living. Our duty extends far beyond that, and we must try to be leaders and educators in those fields for which we are best suited.

Democracy certainly cannot function and cannot progress without the active and enthusiastic participation of every citizen according to his own lights.

—PAUL J. ZENTAY, M.D.
Honorary Life Member
American Social Hygiene Association



As Secretary of Defense, I regard the United Defense Fund as a distinct asset to our country in these critical times.

It provides a logical, orderly means of unifying and coordinating experienced voluntary national health and welfare organizations for the purpose of serving our present defense effort. The United Defense Fund serves everybody.

Through UDF, members of our armed forces are provided with the morale-strengthening facilities of USO Clubs and Lounges, and USO-Camp Shows. These operations are in action now, in more than two hundred strategic locations at home and overseas.

Two additional member-agencies of UDF are of direct service to military personnel. One is the National Recreation Association, which provides trained personnel for diverse recreation programs conducted on military posts. The other is the American Social Hygiene Association, safeguarding health.

The great humanitarian work of American Relief for Korea, and the important health and welfare tasks undertaken by United Community Defense Services are further reasons why UDF deserves the support of all Americans.

A handwritten signature in black ink, located in the lower right quadrant of the page. The signature is stylized and cursive, appearing to read 'Arthur H. H. H. H.' with a long horizontal flourish extending to the right.

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journal of SOCIAL HYGIENE

Vol. 38

October 1952

No. 7

KANSAS CITY, MO.
PUBLIC LIBRARY

OCT 27 1952



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About our cover . . .

A Marine says goodbye. Sixteenth of a series of Journal covers on family life. U. S. Department of Defense photograph . . . courtesy of *All Hands*.

Harriett Scantland, Editor

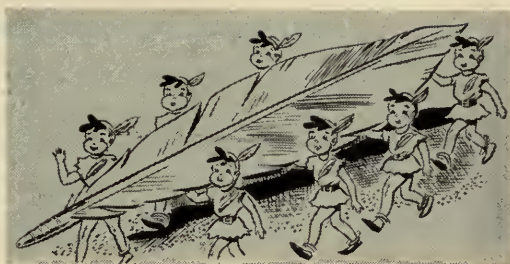
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THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association. Subscription price: \$3.00 per year. Single copy: 35¢.



Sharing Together

Silas lived for 50 years down around the Savannah River, minded his own business, saved his money, shared it where he was *sure* it was needed. Every Christmas he sent baskets around to the 10 or 15 neediest families, families he *knew*. No one was going to call him a Scrooge.

Well, Silas lived to see the giant Savannah River Project open up, to see the gutting of his own town, to see defense plants rise from the ground, manned by rootless workers. He saw soldiers on streets peopled by families whose incomes he could no longer gauge. By the frenzied hour, it seemed to him, homes for the homeless were springing up—for babies, for working girls, here a clinic, there a USO center, a Travelers Aid desk.

In the old days, Silas reflected, there would have been a blustering red-light district instead of all these services.

Seventeen thousand services, someone said, throughout the whole country, and more outside—centers at Casablanca, Pusan—all supported by the Red Feather campaign and the United Defense Fund. How futile those old Christmas baskets, he thought, in the face of this modern complexity!

And so Silas gave one big contribution to the Red Feather campaign. "Got to admit the world's growing up too fast for one person to see the whole picture. It's a big business, this giving, with its planning, budgeting, sharing.

"Heart? There's more heart in Red Feather *fair* distribution, seems to me," Silas concluded.

Join with Silas in making the Red Feather flame with more charity, glow with more cheer—give to the Red Feather campaign.

The VD Hunt Is Still On

Continued Decline Needs Continued Control

by Theodore J. Bauer, M.D.

I am pleased today to be able to report that substantial gains continue to be made in reducing the incidence of syphilis in the United States. Total syphilis morbidity reached an all-time low of 214,000 cases in 1951, a reduction of nearly two-thirds since 1943. This encouraging trend seems to be continuing.

Historically syphilis rates rise in time of mobilization. At the outbreak of hostilities in Korea, we feared that our gains up to that time might well be lost. We were hopeful that our control methods would stand the test. But we realized the test would be severe. We are more confident now.

The continued downward trend over nearly two years of mobilization is a matter of record.

The reason for it is also a matter of record. I refer to the splendid cooperative effort of the military, the private physician, and civilian health agencies—federal, state and local.

There is some inclination to attribute these accomplishments solely to the use of penicillin, widely used both for syphilis and for the treatment of a great number of other ailments. It is true that penicillin is a potent antibiotic and that it has been used as a universal cure-all.

But it is also true that hunters, not bullets, bring home the game. Gonorrhea is a classic example. We have had too few hunters to pursue the gonococcus as relentlessly as the spirochete. We have had to take first things first. As a result:

- even though penicillin is a specific for gonorrhea,
- even though the dosage required is much smaller than for syphilis,
- even though a single injection is adequate, and
- even though the public has been injected with penicillin for all manner of ailments from the common cold to cancer,
- gonorrhea in the United States is declining at a much slower rate than infectious syphilis.

We are succeeding against syphilis—even in a period of mobilization and despite all precedent—not because penicillin has become almost as common as yeast cakes, but because we have hunted for and found syphilis. When we devote the same energy and skill to hunting for and

finding gonorrhea, I am convinced it too will begin to decline as an American health hazard.

There is no foreseeable end to, or relaxation in, the venereal disease control effort short of extinction of the disease organisms. The VD control problem is unique. Generally, the communicable disease control structure rests on a foundation of at least four fundamental operations:

- Immunization of the population
- Isolation of the host
- Elimination of the intermediate host
- Destruction of the organism

In venereal disease control we have no agent for immunizing the population. If one were available, its use would be questioned and its application would be costly.

We *cannot* isolate the host because we cannot always find him. Our diagnostic procedures are not infallible, and our case-finding procedures are only about 50% effective.

We *cannot* eliminate the intermediate host, since there is none.

We *can* destroy the organism—if we find it. But we find it only after it has announced its presence in the host. This announcement may or may not be heeded if noted. Frequently it is never noted.

Thus our entire control effort is balanced precariously on only one of the four elements in the classic foundation of communicable disease control. With the single exception of treatment when the case is found, the odds in this struggle are with the spirochete and the gonococcus.

If we are to maintain the gains we have made to date and continue to extend them in the future, we must keep abreast of the ever-changing demands for service. We must shift our operations and revise our policies to achieve maximum concentration on our major objective—finding and destroying the organisms.

As I see them, the urgent demands for our services are these:

There is a need for complete and accurate interviewing. Not everyone can interview successfully. Careful selection of potential interviewers as well as sound training are imperative. We have demonstrated that when talent and training are combined, the trainees in our interview schools average four to eight contacts per interview. In the areas where such individuals are employed, interviewing is very effective. There are, however, too few such areas.

There is also a need for a place to interview. The Rapid Treatment Center has been ideal. But Rapid Treatment Centers in most areas



*There is need for
complete, accurate interviewing . . .*

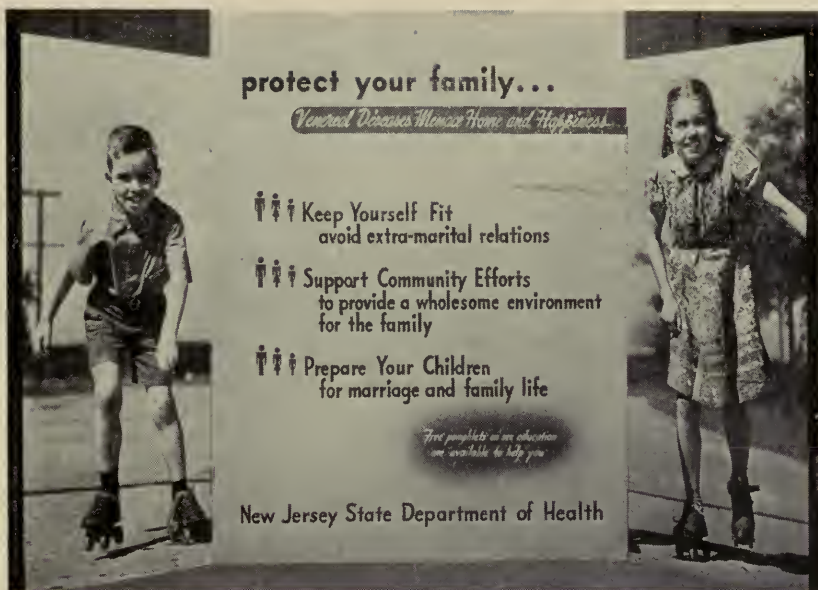
will close in the coming year. Availability of outpatient treatment plus budget economies will permit only a few to remain open.

There is an increasing demand for professional education and training. As the morbidity of syphilis and gonorrhea decline, it will be necessary that every physician who may possibly encounter venereal disease be alerted to seek the opportunity to treat it. When the opportunity presents itself, it will be necessary for him to know how to treat and how to report the case. It will also be important for him to understand the necessity for patient interview and where to obtain interview services quickly.

This is no insignificant problem. Traditionally, private physicians have treated about half the venereal disease in the United States. Today,



*and for
professional
education
and
training.*



many medical students are being graduated without ever having seen an early syphilitic lesion.

There is more need than ever for effective public education. It will continue to be necessary for a long time to remind those who get venereal disease how they get it and what they should do about it. It will be necessary to alert young people who do not have venereal disease to the possibility of infection. It will be necessary for a very long time to alert fathers, mothers, teachers, clergymen and legislators to the necessity for continued vigilance and applied controls.

*There is need for
effective
public education . . .
and for
improved
diagnostic techniques.*



There is a need for improved diagnostic techniques for both syphilis and gonorrhea. This will require continued research and evaluation in establishments where patients are available. Even more important, we must develop techniques for detecting the onset of syphilitic damage to the heart and of preventing syphilitic blindness.

There is and will continue to be a need to find and bring to treatment the civilian contacts of the military. The assignment of competent interviewer-investigators to military establishments during the last year has been of major assistance to state and local health departments in forcing the continued decline in syphilis morbidity in the United States.

How can these needs be met?

As I review these needs for service in the coming year I am also considering how they can be met. In most areas during the past decade, venereal disease control activities have been developed around inpatient service, with its splendid opportunities for interviewing, training, education, diagnosis and treatment, research and evaluation. It has facilitated control operations. Its discontinuance demands a new operational concept and a realignment of our control resources.

During the last year I have had an opportunity to talk about these problems with VD workers in other parts of the country. Out of these conversations there has emerged a proposal for replacing Rapid Treatment Center services with a less centralized facility. This might be called a VD Prevention and Control Center. It is clear that it would be unsound to return diagnosis, treatment and epidemiology to all of the 2,000 local health clinics throughout the country or to develop a great many small new clinics to handle only local cases.

It has been considered sound, however, to select from among the existing clinics a few for consideration as VD Prevention and Control Centers. Those that have been selected for such consideration meet the following requirements:

- They are located in relatively high prevalence areas and in communities which are transportation hubs. This allows economical transportation of patients from outlying communities. It also makes it easier for patients to meet treatment appointments on the outpatient schedules.
- They are designed to provide interview opportunities. That is, they are in areas where the volume of patients warrants full- or part-time interview service and where the establishment itself provides the facilities

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College of Medicine. Former editor of the
Journal of Venereal Disease Information.
Chief, Division of Venereal Disease,
USPHS. Fellow of the AMA.*

Theodore J. Bauer, M.D.



for successful interviewing—privacy, a modicum of comfort, an atmosphere of friendly, purposeful service.

These centers should be in a position to render consultative and technical services to those private physicians requesting them. This should include, whenever possible, interview service (which I believe is most essential).

The Prevention and Control Centers should afford education and training opportunities. It may be that the most advantageous location for such a center or clinic would be as a part of, or adjacent to, a medical school or medical school hospital. In the future, it will be necessary to work much closer with medical schools. The Prevention and Control Center in Oklahoma City, for instance, is located on the medical school campus in one of the medical school buildings. It is partly staffed by medical school personnel.

We are prepared to help medical schools insofar as possible.

Certain of the Prevention and Control Centers must be able to provide clinical material to medical schools for the study of syphilis as it affects the heart, central nervous system and eyes. Others, if not all, should be able to study and apply control techniques for gonorrhea.

Plans are being made in Charleston, S. C.; St. Louis, Mo.; New Orleans, La.; Florida; Mississippi, and other areas to apply and test this VD Prevention and Control Center concept.

In some of the low prevalence areas in this region such a center may not be necessary or practical. There the health departments may wish to provide more service to private physicians in their areas in order to bring them more completely into the control program. Some states assist the private physician in extending his service more widely.

The plan adopted in Idaho has many features to recommend it. For the last three years, Idaho's contract physician plan has grown slowly with the approval and cooperation of the State Medical Society. While it may be impractical to consider its introduction per se into other states, certain parts of it may well be considered.

Earlier, I mentioned that gonorrhea morbidity rates have not come down as rapidly as those for syphilis. I indicated that this results from our lack of personnel in the past to interview gonorrhea patients and investigate their contacts. The question might properly be asked, "Why begin now?"

There are, it seems to me, two answers to that question:

1. The gonorrhea patient is a communication pipeline and an epidemiologic guide to still-undiscovered sources of VD infection. We must interview him and investigate his contacts in order to clear up the scattered pockets of infectious venereal disease—including syphilis—which still remain hidden in the population.

The gonorrhea patient is almost always a member of a young, actively promiscuous circle within which venereal disease incidence is high. From experience we know that little is gained if we find and treat only part of the group. We must get them all. And we *can* get them all only by using every possible entree into their circle.

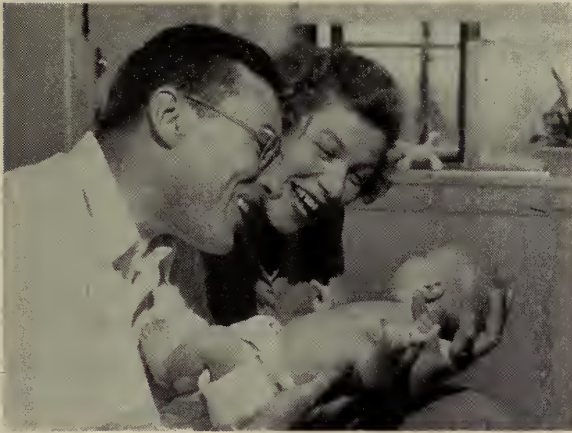
2. The second reason for increasing our interest is that gonorrhea has always been an expensive time-waster. It wastes not only the time of the patient but it also takes the time of the doctors, nurses and technicians who care for him. This constitutes an especially serious drain on military resources.

Our military investment is public-supported and costly. We are reminded constantly that it may continue for a long time. Every misdirected man-day adds to the total cost. Since military personnel get their infections from civilians, the only way to eliminate this needless cost is to weed gonorrhea out of the civilian population and keep it out.

I sincerely hope that in presenting these thoughts for your consideration I have not implied that the course for VD control in the coming fiscal year already has been charted. This is not the case. These comments constitute, at the most, a report to you on deliberations I have had with other health workers during the past nine months.

In each state and locality, the problems are different and to that extent the approaches to the problems are different. In order to utilize Public Health Service resources, however, it is necessary to develop a basic pattern of operational plan and activity. But such a plan must grow out of the real needs of the people who serve and the people who are served. The Division of Venereal Disease can act as an effective catalyst in the development of this operational plan.

In conclusion, I pledge you every assistance at the disposal of the Division of Venereal Disease, as you determine what you wish to do and how you wish to do it.



THE LOVE STORY OF AN AMERICAN FAMILY

by Rabbi David Jacobson

This is the story of Sally and Gene Cohen, two very happily married people, together with their children, Richard and Louise, with a third on the way.

The Cohen family forms an ideal household. Their contentment derives from their physical and mental health, which in turn is strengthened by their religious attitudes and practices. The editor of the *Journal of Social Hygiene* has asked me, a rabbi, to tell about the Cohen family, because she believes that a case study of a successful home might show what factors go into the environment that the American Social Hygiene Association tries to encourage.

The Cohen family is Jewish and they have certain traditions which are a part of their faith. These traditions are much the same as those held by Protestants and Catholics, since we all share in the Judeo-Christian attitude toward life. Every study has demonstrated that Americans of similar economic and vocational status have very much the same outlook and practice.

Therefore, the Cohens have just about the same attitudes, hopes and fears as their friends, both Christian and Jewish. Their religious worship, however, is centered about the Sabbath—which begins Friday

night at dusk and continues until sunset of Saturday evening—and their religious schedule is somewhat distinctive. Those who are Protestant or Catholic will quickly note that except for certain changes of ritual, the great ideas and ceremonies which bind people together in their disciplines are found in the pattern of Jewish observance.

In order to see how this family began, let us go back to their first interview with me, their minister, when they came to see me some years ago to confide the happy news of their intended marriage.

They liked the same things

To begin with, the two of them had a great many things in common and therefore the chances of their getting along well were most favorable. Both were of the same religion. They came from happy homes of about the same economic status. Their schooling and intellectual interests were similar. Sally shared Gene's interests in sports, such as baseball, fishing and bowling. And Gene was quick to laugh at the same situations Sally thought amusing. They each had a fairly wide circle of friends whose company they enjoyed, and each accepted and was liked by the social group of the other.

Although they had lived in the same community and had known each other casually for many years, they had begun to date steadily just before the infamous day of the Pearl Harbor attack. More and more they had come to the inevitable conclusion that they wished to spend the rest of their lives together.

The war, of course, blasted any hopes of an early marriage. Gene put on his country's uniform and served "stateside" and overseas. They kept in close touch by regular correspondence and occasionally they arranged to see each other.

Self-respect and mutual love sustained them during the trying years, and strengthened them to resist the temptation of sexual indulgence. The problem was more difficult for Gene, because he was away from home. They had, however, early resolved that their only sexual experience would be with each other, after marriage.

Shortly after V-J Day, Gene was discharged from the service and returned home. Fortunately, like most young veterans, he found a job he liked which offered opportunities for the future. He and Sally decided to get married at once. Their families concurred. Then they made an appointment to see their minister.

A premarital interview

When Sally and Gene explained that they were planning to announce their engagement and wanted to talk over their marriage plans with me, they wisely recognized that their minister, who is deeply concerned about

their well-being, also has had training and experience in marital and premarital counseling over a period of many years. In our discussion, which lasted two hours, we talked over many things, particularly itemizing their plans to make this marriage as perfect as any marriage could possibly be.

One of the problems: What to do about Gene's widowed mother? They thought she might be lonely if she did not live with them, but we soon came to the conclusion that it was very important for young people to keep their domicile exclusively their own. How very right the Bible is when it says, "And the man said, 'This is now bone of my bone and flesh of my flesh!' Therefore, shall a man leave his father and his mother and shall cleave unto his wife, and they shall be one flesh."

Children? Of course!

Sally brought up a matter: They would both have to work to make ends meet but they certainly wanted children. How could they resolve this dilemma? Again, it did not take too long to work out a budget so that—while they lived very simply—they could put aside some money each week for the future. Sally decided she would take some evening courses in domestic science so that she would be able to run her household efficiently and economically. They would even be able to make provision for some life insurance and medical insurance. Besides, their families promised to help them out a bit financially.

Neither of them had read any good books on marriage, and so a number were recommended. Some laid stress on the biological aspects

*Gene fought
and
Sally waited.*



of marriage and others on the economic and psychological. While Gene admitted that he was frequently short of temper, Sally confessed that she was not the best housekeeper in the world. But they both agreed they would try very hard to improve their weaknesses, and they made definite rules about never permitting the day to end unless any conflict that might arise between them was lovingly settled. They would never bear a grudge against each other. They would try hard not to take out their anger or dissatisfaction with things in general against each other, nor carry hostilities into their home.



*His wife was the light
of Ezekiel's eyes.*

The two of them wanted to have the wedding in the synagogue, and this too augured well for their future . . . because weddings under church auspices have much greater chances for success. Then I, as minister, told them something about the established ideals of Judaism in regard to marriage—all these ideals being generally prevalent in the United States.

Look upon no woman

- First of all, I stressed the ideal of monogamy and faithfulness to one's wife or husband.

The passage from the Biblical Book of Proverbs, "Rejoice in the wife of thy youth; be thou ravished with her love," represents the one-man, one-woman relationship. From the commandment that prohibits adultery to the covenant which Job made with his eyes "not to gaze upon an unmarried woman," the single standard of morality is constantly in evidence. I quoted the admonition of the Talmud addressed to every married man, "Look upon no woman, fair or homely, married or unmarried."

The Talmud regards it necessary for the man and woman to keep free from suspicion . . . and throughout the ages the standard of complete marital devotion of the husband and wife to each other and to none other has been stressed and emphasized.

- Then I indicated the importance of expressing one's love by affection and constant attention to the other.

In the Bible there are many expressions of such sentiment as, for example, that of Abraham for Sarah, of Jacob for Rachel, of Ezekiel

for his wife, who was "the light of his eyes." The wife mentioned in the 31st chapter of Proverbs happily discovers that, "Her children rise up and call her blessed; her husband also, and he praiseth her."

A Talmudic adage is this, "Let a man be scrupulous about honoring his wife, because whatever blessing prevails in a man's house, is there because of his wife." "Whoso loves his wife as himself and honors her more than himself, shall obtain the scriptural promise, 'Thou shalt know that thy tent is in peace.'"

To merit respect

There are many statements dwelling upon the wife's regard for her husband. The emphasis, however, is always on the fact that the man must merit his wife's respect in order to retain it. On the other hand, the Talmud points out that the wife should not be quick-tempered, should be a good housekeeper, should dress becomingly, should avoid flirtation and conduct herself modestly.

- Another ideal has to do with the responsibility that rests upon the husband and father to maintain the family. Although women may on occasion work, the obligation of supporting the family is always the husband's. As a Talmudic authority puts it, "Whoever counts upon the earnings of his wife will never experience blessing."

- Another primary ideal is that of continuous education, adult as well as juvenile. Since study has always been held to be one of the ways in which a person worships his Creator, books are to be as much a part of the furniture of the home as the table and bed, and youngsters particularly are to be encouraged to grow continuously in understanding.

The purpose of knowledge is good works. One should take a creative part in the community in which he lives, through organizations, discussion, volunteer service, intelligent voting and all the other ways by which each person is expected to contribute to the welfare of those around him.

- Not the least of the safeguards to happiness in the home was a plan for religious observance. Gene and Sally agreed that from the very beginning of their married life they would begin their day with prayer, offer a blessing before their meals, and express their gratitude at eventide for the day that had passed.

The Sabbath

The high point of the week is the Sabbath, which begins Friday evening. The evening meal is supposed to be particularly special that night, and the best dishes and linen are used. The table then becomes converted into a kind of altar in which the husband is a priest and the wife a priestess.



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First, the wife lights the Sabbath candles with this prayer, "May our home be consecrated, O God, by Thy light. May it shine upon us all in blessing as the light of love and truth, the light of peace and goodwill. Amen."

Then the husband offers a prayer, welcoming the Sabbath as a symbol of joy and peace and as the termination of a week of life, health and strength, of home, love and friendship. He expresses their gratitude for the discipline of their trials and temptations and for the happiness that has come to them out of their labors. And he concludes with the reading of portions of the 31st chapter of the Book of Proverbs, which is an expression of praise of the wife and a review of the ideals which shall be found in the home.

After the sanctity of the Sabbath is proclaimed and thanks are offered for God's gifts of food and love, the father asks God's blessing on the children. Then the members of the family kiss each other, and in this atmosphere of affection and goodwill the Sabbath meal is eaten.

Following dinner, Friday night is to be spent in the synagogue, where the prayers, the sermon and the music are all designed to help evaluate life, to set standards, and to make judgments about the right course people should choose. During the cycle of a year, with its recurrent holidays and holy days, the theme of God's need for man and man's need for God is repeated—as through the movements of a symphony—with many variations.

At the same time, the worship experience exposes the participants to the many angles of radiation which faith, tradition and judgment play upon the worshippers.

The wedding

Gene and Sally were married . . . and a very happy occasion it was. Relatives came from all over, and their friends, of course, filled the synagogue and offered their very best wishes at the reception that followed the ceremony.

The first year or two were filled with the joy and activity of a newly-married couple . . . with a host of friends, with resolutions about the

future, and with the active need to make these resolutions come true by study and work. They did not fail to put into effect their early commitments. This was not easy, for the days went by so fast and the struggle—to make a living, to put something aside, to continue learning—took up much of their time and sometimes frayed the edge of their good resolutions.

Toward the end of her first pregnancy Sally quit her job. The two of them attended a number of public lectures on child-rearing given by some of the psychiatrists in the community, and they came to the conclusion that the best advice, which all these lectures comprised, had to do with living a kind and good life, a natural, simple life, with love and affection for each other . . . now to be extended to their child.

The old rules still apply

Out of the experience of their early wedded years, they realized that many of the warnings and forebodings about the difficulties of physical and mental adjustment to marriage had proved unnecessary, for the old rules about good living and good thinking and good doing are still applicable in the present day. They also came to the realization that children had been born through all the generations and that the accumulated wisdom of the past could stand them in good stead for the upbringing of their offspring, as in the establishment of their first firm years of life together.

And so indeed it proved to be. They discovered that the synagogue, as is true of the church, had made provision for people of all ages to mature under the most helpful conditions, in the nursery school, the religious school, the youth groups, the adult study groups and the Brotherhood and Sisterhood organizations.

*The wedding in the temple
augurs well for the future.*





*Their children
were growing up.*

The home, too, is a sanctuary. The same ideals which are expressed in the church by prayer, preaching and practice are also found in the home.

The sixth chapter of the Book of Deuteronomy presents the great creed of the Jews: "Hear, O Israel, the Lord our God, the Lord is One." This doctrine affirms the fatherhood of God and assumes the brotherhood of man. Immediately after this statement comes the command, "And thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy might. And these words, which I command thee this day, shall be upon thy heart; and thou shalt teach them diligently unto thy children, and shall talk of them when thou sittest in thy house, and when thou walkest by the way, and when thou liest down, and when thou risest up."

This ordinance obliges parents to introduce into the home an atmosphere of spirituality. As a result, most of the holidays are observed with domestic ceremonies.

The home — guardian of freedom

For example, Passover comes in the early spring. It is a week-long festival of freedom, recalling the exodus of the ancient Israelites from the harsh slavery of Egypt. The story of freedom lost and freedom regained is told around the dinner-table in a narrative intended particularly for the young people. The ideal of personal freedom and the importance of seeking freedom for all people is stressed, together with the fundamental truth that liberty can be found only where law and order, morality and justice reign.

Thus, the home is understood to be the guardian of freedom of every country, and ethical living on the part of the members of the household is equally necessary for liberty and democracy.

Another holiday whose center is in the household is Chanukah, an eight-day festival. It recalls the refusal of the Jews who lived in the

second century B.C. to give up their right to worship God as they wished. If it had not been for the holiday of Chanukah, Judaism would have perished and neither Christianity nor Mohammedanism would have been born.

This important mid-winter occasion is marked by impressive ceremonies, including that of the lighting of small tapers in a candelabrum, one for the first night, two for the second night . . . until finally eight are glowing at holiday's end. With each light kindled and a prayer offered, a particular ideal of religion is stressed, such as justice, holiness or honesty. Presents are afterwards distributed to the members of the family.

Holy days unite the family

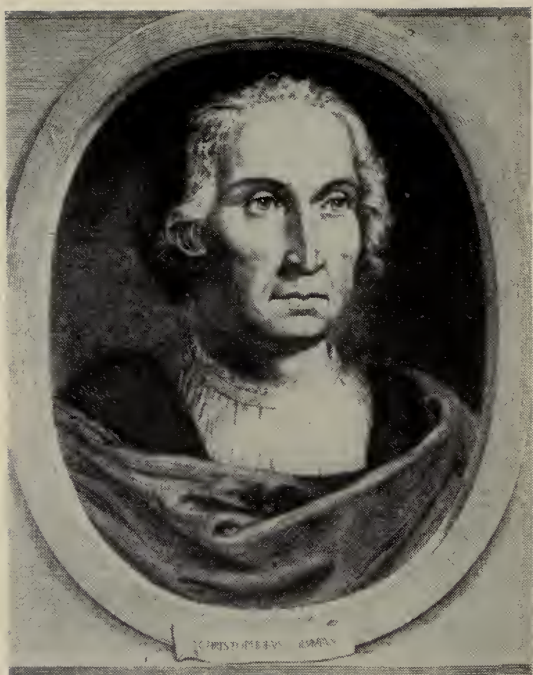
Here again the hearts of the parents are turned to the children and the hearts of the children to the parents, and the bonds of love are entwined among all the members of the family group. Needless to say, Gene and Sally Cohen and their children discovered that the ceremonials and holiday observances were a two-way passage that brought them closer to each other, and consecrated them to God and goodness.

With their children gradually introduced to the facts of life (of which sexual information was only one item), the Cohens found that growing up and maturing were only a process in the miracle of life—a miracle that might seem commonplace because it was happening all the time, but amazing nevertheless. It was only when individuals and groups were burdened by fear or ill-considered behavior, or by immoral activities, inadequate recreation or a weakening of their religious responsibilities, that frightful things happened to them. They saw that this applied in every group, small or large, in the family or in the family of nations.

Barring the accidents and catastrophes that can sometimes occur to people everywhere, the Cohens, like most individuals in America, form a happy family unit, and they face the future with courage and confidence.

A light unto their paths

They would give as their advice, on the basis of their experience, much the same counsel as that which Rabbi Elijah De Veali, of the 18th century, offered: "I suggest that you live together in love, brotherliness and friendship. For it is good and lovely when you dwell together as one, with peace within your walls which makes for prosperity within your house. And as for you, O husbands, I say to you: Honor your wives; and let the wives do full honor to their husbands. Be faithful shepherds of your flocks, watching your offspring, regarding their doings, wisely leading them to graze in the garden of the Lord. And as for you, your conduct should always be a light unto their paths."



COLUMBUS,
CHARLES VIII
AND THE SERPENTINE DISEASE

by Charles Walter Clarke, M.D.

The Men from Heaven and the Tainos

On Christmas eve, December 24, 1492, near midnight, the little Spanish ship *Santa Maria*, with sails down, rose and fell with the swells. Not being anchored, it drifted imperceptibly with the current.

Christopher Columbus had been on deck and without sleep for two days and a night guiding his little fleet eastward along the northern shore of the island which he called Espaniola but which now bears the name Haiti. The master of the *Santa Maria*, whose watch it was, had already retired, leaving the helm in the care of an experienced seaman. Columbus, tired but happy, remained on deck.

Fresh in his memory was that other night when at two in the morning of October 12 he had caught the first glimpse of a new but unrecognized world, a night which—as S. E. Morison says in his *Admiral of the Ocean Sea*—was “big with destiny for the human race, the most momentous ever experienced aboard any ship in any sea.”

Now he thought of the beauty of the numerous islands he had seen, of their luxuriant vegetation, of the strange fruits in their deep forests, the unfamiliar birds in their balmy air and the weird fish in their clear blue waters—providing, with but little labor, abundant food for men.

He considered the friendliness of the people who had crowded unafraid to each shore, beginning with San Salvador on which he had first landed and raised the standard of his sovereigns, Ferdinand and Isabella, and planted the cross of Christ, taking possession in the names of the temporal and spiritual authorities he served. A pious man, he thought of how easily the simple natives could be Christianized if devout priests came among them and learned their language. A man of his and not a later age, he thought how profitably these same potential Christians could be enslaved.

A gentle, graceful people

In his *Journal of the First Voyage* Columbus described the people he encountered on San Salvador and the other islands including Juana—our Cuba—and Espaniola. Of them all, he found the Tainos, natives of Espaniola, most attractive. Now he thought of how straight-limbed, erect and graceful of movement they were, how pleasing their golden brown color—many were as light as the people of Castile—how beautiful their eyes and straight black hair, not curly like that of the natives he had seen on the African coast.

Their natural beauty was freely displayed to the eyes of the Christians on landing from their ships, for the Tainos “were naked as the day they were born.” The people of some islands painted themselves black, red or white, and some women wore a narrow belt about the waist with a small apron or fringe covering “the nudities.” Where painting of the body was the custom, females seemed more embarrassed without their paint than without the little aprons.

Gifts of gold

The Tainos were not a warlike people; they had no weapons except sticks tipped with pointed shells or bones. Columbus had seen one armed Christian put a whole village to flight. The kindly generosity of the Tainos impressed the white men: “They gave freely whatever was asked of them.” When with signs and a display of gold objects the Spaniards indicated their desire for gold, the natives brought the few ornaments

contained in their homes, gladly giving the Christians talismans of gold which had required generations to collect.

To the Tainos the Spaniards were "men from heaven," and when the white men explained that they really came from Castile the natives believed that Castile was a part of heaven.

The Tainos men came and sat in a circle around the Christians, looking searchingly at them and feeling their bodies to learn whether the "men from heaven" were indeed beings like themselves. And when the male Tainos left the females came, bringing gifts of food or whatever they thought the Christians might desire and likewise sat in a circle about them, embracing the Christians' hands and feet.

Tobacco firebrands

The Spaniards were puzzled to see Tainos men and women carrying about with them by day as well as night small firebrands made of brown leaves rolled into a kind of baton. To keep the firebrands burning, they placed one end in a nostril and inhaled. The lighted end glowed and produced much smoke but no flame. They were therefore of little use for illumination.

When the Spaniards inquired as to the purpose of the firebrands, the natives indicated that they got some kind of pleasure from the process of keeping them alight. Naturally, the Christians tried inhaling the smoke from the firebrands, but because it made them sick they concluded that this was an evil practice and advised the Tainos to stop it. They replied that though they often tried they never succeeded in giving up the practice of smoking the firebrands made from the leaf of a plant called by them "tobaco."

Thus far, Columbus had induced his men to deal gently with the Tainos because, he reasoned, a friendly population would be more willing than a hostile one to bring him the gold he needed to carry to his king and queen.

With these thoughts and a prayer the admiral went below to sleep.



*La Navidad
on Espaniola*

En route to Manila, Dr. Clarke, ASHA's executive director for 15 years, now a Fulbright professor at the University of the Philippines, and Mrs. Clarke receive the traditional Hawaiian greeting.



A man of presence

Columbus was a man of commanding presence, a tall figure of great dignity. His hair, bright red in youth, was now after 42 years white but plentiful. His blue eyes looked with confidence and frankness from a long face of light complexion but bronzed by life at sea, with high cheek bones and long aquiline nose.

His garb was conservative as was also his language. "Now by San Fernando" or "God take you" were his worst curses. He never ate nor drank to excess.

Although he came near having a mutiny on his ships a few days before land was first sighted, his persuasiveness averted that disaster, and now as a successful leader his captains and crew respected him, though some were jealous and some disloyal.

The crew, like the admiral, was tired. The calm peacefulness of the night, thoughts of home on Christmas eve in faraway Palos, from which most of the sturdy seafarers came, the fatigue of working the *Santa Maria* along the coast, and now the apparent security and the gentle roll of the ship invited sleep.

A novice at the helm

The sailor whom the master of the ship had left at the helm quietly turned the tiller over to a boy and slipped below deck. He too went to sleep. The fate of the *Santa Maria*, a league off shore, was in the hands of an inexperienced lad.

"It pleased our Lord," wrote Columbus in his *Journal*, "that at 12 o'clock at night when the admiral had retired to rest and when all had fallen asleep, seeing it was a dead calm and the sea being like glass, the tiller being in the hands of a boy, the current carried the ship on one of the sand bars. If it had not been night, the bank could have been seen and the surf could be heard for a good league. But the ship

ran upon it so gently it could scarcely be felt. The boy who felt the helm and heard the rush of the sea cried out."

Columbus immediately returned on deck and took command. Had the master of the ship who now came tumbling on deck obeyed the admiral's orders and taken an anchor in the ship's boat and dropped it well astern, the *Santa Maria* might have been eased off the sand bank. But the master, even though he was part-owner of the *Santa Maria*, thinking only to save his own skin, fled in the boat he had launched at the admiral's command and tried to take refuge on the *Nina*, which lay to leeward.

Meantime, each swell lifted the *Santa Maria* higher and dropped her with more violence on the sand bar. Columbus, hoping the ship might be carried safely over the bar, ordered the *Santa Maria* lightened. Though the masts were cut away, the ship—battered in the surf, turned broadside to the waves and rolled and pounded increasingly—was driven higher and higher aground. The seams of the sides and the decks opened, and the ship began rapidly to take water. Seeing this, Columbus at last gave orders to abandon ship and went with members of his crew to the *Nina*, which he boarded just at dawn of Christmas morning.

During the night, men were sent ashore to bring news of the disaster to the local Tainos chief or "king," as Columbus called him, with whom the Spaniards had had a friendly encounter a few days previously.

Scarcely had daylight revealed to the Tainos the wrecked *Santa Maria* when the king, attended by some of his people, came in canoes to comfort Columbus. "The king said to him, almost weeping, that he need not be sorry for he would give him all he had; that he had placed two large houses at the disposal of the Christians who were on shore and he would give more if they were required . . . with all the canoes and men necessary to unload the wrecked ship to the shore."

No better land, no better people

The king undertook to protect all the goods on the ship and, wrote Columbus to Ferdinand and Isabella, "There could not have been so good a watch kept anywhere in Castile—not even a needle was missing—they were a loving people without covetousness. I assure your highnesses that there is no better land or people. They love their neighbors as themselves and their speech is the sweetest and gentlest in the world and always with a smile."

These are the people—the beautiful, generous, peaceful, friendly Tainos—who are alleged by certain medical historians to have transmitted syphilis to "the men from heaven" and, through those who returned with Columbus to Spain, to have launched an epidemic which spread the disease throughout the civilized world in only 12 years!

In his piety, Columbus took the entirely unexpected wreck of the *Santa Maria* to be a sign that it was God's will that the Spaniards should

build at this point the post and fort which Columbus had determined to establish. He soon was persuaded by his reverent regard for the Ruler of Man's Fate and by the solicitude of the Tainos that a good and not a bad fortune had befallen him.

La Navidad

Promptly he set about building a fort—using timbers from the *Santa Maria*—and in devout recognition of the day on which their ship was cast ashore he called the place La Navidad or Nativity. This first attempt at settlement was located about five nautical miles east of the present city of Cap Haitien and three and one-half miles west of Caracol Bay.

With the help of the Tainos, the fort was soon completed. Columbus assigned 44 men, including five in command status and two physicians, as the garrison for La Navidad. He then sailed away to Palos and a glorious welcome by his sovereigns—the only royal welcome one of the bravest human beings and greatest navigators of history was to receive in his lifetime.

Devastation

When Columbus returned to La Navidad on November 28, 1493, he found the fort destroyed and not one of his garrison living. There were bits of evidence about the site—a few scraps of clothing and broken tools and crockery—which suggested violence. At first no friendly Tainos appeared to welcome the admiral or explain the fate of the Christians he had left at La Navidad. At length the Spaniards found a few natives who appeared to be very much frightened, as if they feared revenge.

They gave conflicting stories. "The men from heaven had been killed by a neighboring warlike chief." "They had quarreled about gold and

*The Santa Maria,
intrepid
and ill-fated.*



women and killed each other." "They had died of a violent disease." It was finally concluded that the Spanish garrison had so abused the natives—especially by taking their girls and women and by plundering their homes and villages in search of gold—that the gentle people had at last risen and killed them all.

So ended, almost before it began, the first Spanish effort to colonize and exploit American soil and people. Nothing now remains of La Navidad.

The rapacity of the revenge taken by the Spaniards and the brutality of their subsequent exploitation of the Tainos is almost unbelievable.

It was the great misfortune of the Tainos that their women were attractive and that their streams rushing down the mountainsides to the sea carried with them in some places a few ounces of gold. The natives had learned to pan this gold out of the sand and had painfully, during many years, collected enough to give the false impression of a plentiful supply of the precious metal and to arouse the Spaniards to a furious pitch of avarice.

The Tainos seemed willing to share their women with the Christians, but when each of "the men from heaven" insisted on having many women and girls the natives resisted the white men as they had long resisted the Caribs. These warlike inhabitants of the Caribee islands frequently raided Espaniola. The male Tainos they captured were eaten. The young females were preserved alive and fed well for breeding purposes. The Caribs considered Tainos babies a great delicacy.

Revenge

The Spaniards exacted from the Tainos a regular tribute in gold dust of an amount which could not possibly be delivered. Failure to produce the required amount of gold, resistance to providing gratis ample food supplies for the Spaniards, objections to the sexual enslavement of their women . . . all alike led to torture, imprisonment and death for the Tainos. Thousands of natives were killed, others starved and many sickened and died.

So devastating was the greedy and lustful attack of the Spaniards upon the Tainos that whereas according to Morison there were estimated to be 300,000 Tainos on Espaniola in 1493, by 1512 there were no more than 20,000 by actual count. In 1548 it was estimated that no more than 500 remained.

The Tainos were unfit for slavery. The Spaniards were not long in concluding that the sturdier, less sensitive African Negroes would be more serviceable, and they began in 1502 to import them into Espaniola. Today no trace of the gentle, pleasing Tainos remains. A few of their genes may mingle with those of the Negroes in the population of Haiti.

The world will never know what contributions to its cultural life the Tainos might have made . . . what artists, scientists or soldiers they might have produced had they survived.

The Columbian Theory of the Introduction of Syphilis into Europe

After a superb feat of navigation, after surviving several violent tempests at sea, Columbus with his two remaining ships, the *Nina* and the *Pinta*, arrived at Palos, Spain, on March 15, 1493, with 46 white men and 10 natives of the West Indies, *soi-disant* "Indians."

Pinzon, the master of the *Pinta*, went to bed immediately upon arrival at Palos and promptly died. An Indian died at about the same time. These men at least could bear no responsibility for bringing syphilis from the New World to the Old.

In due course Columbus proceeded to Seville and then to Barcelona, where Ferdinand and Isabella welcomed him and confirmed his title and rights as Admiral of the Ocean Sea, a title still borne by one of his descendants, a young Spanish naval officer who recently visited the United States.

Not enough men, not enough time

Some medical historians (but fewer as more is known about the biology of the disease finally named "syphilis") contend that these few men spread syphilis in Spain. They maintain that the disease leaped the Pyrenees in time to infect the soldiers, mercenaries in large part, and the hordes of camp-followers collected in the summer of 1494 in the south of France under Charles VIII. This army spread the disease en route to Naples. In and around this city it became epidemic, taking a very violent form because—it is alleged—the infection being new to Europe, no natural immunity existed.

Because of this scourge Charles was forced to abandon the siege of Naples. When his army broke up, the soldiers, carrying the new disease with them, hitch-hiked back to their homes in all parts of Europe.

Thus syphilis became generalized in Europe and was quickly spread by explorers now roaming as far as China. The new disease, appearing first in Spain in 1493, was recognized halfway around the world in China by 1505 . . . only 12 years after 54 men who had been in contact with the Tainos returned to Europe.

One may examine this theory with a skeptical eye first by setting down the alleged epidemiologic events and then by considering for each event the known facts about the movements of Columbus and his men and some other pertinent data.

Epidemiologic time-table alleged in the Columbian theory of the introduction of syphilis into Europe . . .

(1) Columbus and his crew arrived at Palos, Spain, on Mar. 15, 1493, and at Barcelona, Apr. 15-20, 1493, on returning from the first voyage to the West Indies.

(2) Dr. Díaz de Isla wrote that in 1493 he treated some members of Columbus' crew who were infected with "bubas" or "the serpentine disease," later called syphilis.

(3) Columbus' crew and his Indians had syphilis and spread it wherever they went in Portugal and Spain. The disease spread rapidly in the population.

(4) Some of the infected Spaniards joined mercenaries from all parts of Europe collecting in the summer of 1494 in the south of France under Charles VIII. On Sept. 8, 1494, Charles VIII and his army crossed the Alps into Italy and entered Naples on Feb. 22, 1495.

(5) A violent epidemic of "syphilis" broke out among Charles' troops, forcing withdrawal from Naples on May 20, 1495. The army became disorganized and broke up, and soldiers made their way home as best they could . . . spreading "malignant syphilis" as they went.

Historical facts regarding time, number and movements of Columbus' crew and captives and a few other facts . . .

(1) Correct. There were 46 Spaniards and 10 Indians on arrival at Palos. Pinzon, master of the *Niña*, died soon after arrival at Palos. An Indian died before Columbus went to Barcelona. This left a total of 54 men. Columbus took one officer, a "few" servants (possibly crewmen) and six Indians to Barcelona.

(2) De Isla wrote this in 1530, long after the alleged event. He claimed to have had 40 years' experience with this disease, which would mean he had seen it at least three years before the return of Columbus' crew from the West Indies.

(3) Columbus notes in his *Journal* that there was no sickness on his ships, except that one old man had an attack of "gravel."

(4) On Sept. 25, 1493, a year before Charles entered Italy, Columbus set sail from Spain on his second voyage to America, taking with him "a considerable number" of men from the crew of his first voyage . . . thus reducing the number who could have been in Charles VIII's army. There is no proof that any of Columbus' crew actually joined Charles' army.

(5) (a) The contemporary descriptions of this epidemic at Naples do not resemble syphilis as we know it, nor did anyone then ascribe it to men returned from the West Indies. (b) Assuming that all of Columbus' 44 white men and nine Indians had infectious syphilis, the epidemiology of the disease as known today makes it incredible that they could have launched such an epidemic, especially as "a considerable number" were in Spain only from Mar. 15 to Sept. 25, 1493.

(6) To aid King Ferrand of Naples in defense of his city, Ferdinand and Isabella sent Spanish ships, whose crews augmented the number of syphilitic men in and around Naples.

(7) By 1495 syphilis had already been noted by physicians in Spain and France. Following the scattering of Charles' men to their homes, it was carried by returning troops and reported in Germany and Switzerland in 1495, in Holland and England in 1496. Vasco da Gama's men carried it to India in 1498, and it appeared in China in 1505. Thus, according to this theory, syphilis became worldwide in 12 years!

(8) In 1530 Fracastorius, a physician-poet, published the most famous medical poem ever written, *Syphilus Sive Morbus Gallicus*, in which he described a disease. The name "syphilis" (from a Greek word meaning "shameful, hideous, deformed") became the accepted name for this disease.

(6) The ships sent by the Spanish sovereigns arrived after Charles had already started home, leaving a garrison in Naples. They could not therefore have contributed to the "epidemic" along the route of Charles' returning army.

(7) A "new disease" was noted by some physicians, while others at the same times and places claimed the alleged "new" disease was one long known to them. At the very time Columbus was landing at Palos in 1493, an edict was issued at Paris for the control of the "grosse pox"—a name for syphilis. Before Charles' army escaped from Italy, an order was issued in Germany concerning "the French disease" or "evil pox." "Bubas" and "venereal leprosy" were already well-known throughout Europe. "Gonorrhea" had been known and named for 2,000 years. Lesions now believed to be syphilitic were described in Chinese manuscripts dating back 17 centuries before Christ!

(8) Fracastorius did not, however—any more than other physicians of the time—distinguish syphilis from the mass of other venereal and skin diseases, including leprosy, tuberculosis, psoriasis and carcinomata.

The Columbian theory of the introduction of syphilis into Europe holds

- that syphilis did not exist in Europe prior to the return of Columbus and his men from the West Indies
- that syphilis did exist in the West Indies
- that Columbus' men acquired the disease in the West Indies and brought it to Europe where it was quickly disseminated by the soldiers who joined in the siege of Naples under Charles VIII.



How syphilis spread, according to the Columbian theory.

Venereal Leprosy

As to the first point: A condition called “venereal leprosy” was commonly recognized throughout Europe, North Africa and the Near East. There exist many adequate descriptions dating from long before Columbus. The scholarly research of Dr. R. C. Holcomb has produced convincing evidence that venereal leprosy was in fact syphilis.

Venereal leprosy was spread by sexual contact. It began with a sore on the genitals. It was transmitted by a “leprous” woman to her child before birth.

Syphilis has these characteristics . . . leprosy does not.

Of special significance was the fact that venereal leprosy was “cured” by mercury, while ordinary leprosy was not. Syphilis, too, was “cured” by mercury, and this was the principal drug used for the treatment of syphilis until 50 years ago.

The pre-Columbian cemeteries for lepers in Europe contain long bones and skulls having the characteristic markings of syphilis.

In his article, “The Antiquity of Congenital Syphilis,” Holcomb gives a case history written by Bernard de Gordon at least 150 years before the discovery of America, which states: “Everyone ought to guard himself against lying with a leprous woman, for I will cite what happened concerning a countess who came leprous to Montpelier, and was under my treatment. A certain bachelor in medicine who was attendant to her, lay with her and she was impregnated, and he was made completely leprous.”

Leprosy does not, as Bernard de Gordon thought, spread by sexual intercourse. Syphilis does.

A condition called "bubas," known for centuries before Columbus, was probably a confusion of syphilis, chancroid, granuloma inguinale and lymphogranuloma venereum.

The "New" Disease

The Columbian theory adherents point to the fact—undisputed—that early in the 16th century many physicians in Europe were describing a "new" disease having some of the characteristics of syphilis as known today. This could be explained as a natural result of the sales promotion of guiac, a resin from "holy wood," as a God-given cure for syphilis.

The then-current theory—religious and medical—was that when divine justice visited a plague on sinful man, divine mercy at the same time and in the same place provided the cure. Since guiac came from the newly-discovered West Indies, it was necessary to find a new disease to match. The trade in guiac reached large proportions and was very profitable to the Spanish sovereigns and to the church as a result of vigorous sales promotion.

This was a period of great intellectual activity in Europe. The Renaissance was coming into full flower, and no event did more to stimulate inquiry than the opening by Columbus of a path to the New World. Physicians shared with other literate men in a rebirth of the scientific outlook, dormant through the long Dark Ages. They were describing for the first time many diseases other than syphilis.

Disease predates diagnosis

The 16th century saw the first adequate descriptions of diphtheria, typhus, whooping cough and rheumatic fever. Not until the 17th century were typhoid fever and measles accurately described, and yellow fever, epidemic cerebrospinal meningitis, influenza, chicken pox, relapsing fever and sleeping sickness had to wait until the 18th century before they were separated as diseases and given their own identities.

It was not until much later that the several venereal diseases were separated one from another and clearly understood to be clinical entities.

No one contends that typhoid did not exist until it was described. Why conclude that because syphilis was first named and confusedly described in the 16th century, it was in fact a disease new to Europe?

For proof of the second point—that syphilis *did* exist in the West Indies prior to the first voyage of Columbus—the older medical historians depended on the statement of some scientists that osseous syphilis had been diagnosed in pre-Columbian bones of American aborigines. This is now very far from certain. Dr. A. Hrdlicka, an American medical archeologist of great experience, has stated that among the thousands

of pre-Columbian bones he has examined he has never seen one which was certainly syphilitic.

Columbus' party on the first voyage included three physicians, but there is no mention in his *Journal* of the first voyage to the West Indies of any disease observed by these trained men among the natives. In fact, they were described as especially healthy, happy people.

A healthy lot — the crew

The incubation period of syphilis is from 10 to 90 days. From the time of Columbus' first contact with natives until his ships returned to Palos, there was ample time for syphilis to show among his crew—if they had acquired the disease. But they successfully worked the *Nina* and the *Pinta* through terrific storms on the eastward passage.

It was as if the elements were determined not to let the secret of the existence of a great New World escape to the Old. Many times the seamen prayed that the storms might abate. In the midst of the most violent attack of wind and waves on the tiny ships, Columbus stood on the poop deck and with his sword drew a circle about him on the deck and the sign of the cross in the sky. He seemed to know positively that it was God's will that his ships would survive.

But they could not have weathered the assaults of the gales if the crew had been sick—and we have Columbus' word for it that his men were not.

There is, on the contrary, some evidence that the Spaniards conveyed syphilis to the West Indies. A careful historian, Las Casas, wrote between 1527 and 1550 that on returning to the West Indies on the third voyage Columbus found the native women generally infected with "the" venereal disease and so also were the Spaniards of the garrison—all except "those who were chaste."

Charles — "The Fathead"

The Columbian theorists' third point is hardest to believe—that 44 Spaniards and 10 Indians started an epidemic in the army of Charles VIII and that from these soldiers the disease spread rapidly over Europe and within 12 years to China!

The timing of this alleged chain of events requires that it should have been the men from Columbus' *first voyage* and not any subsequent voyage who first brought syphilis to Europe. The later voyages did not return until after syphilis is supposed to have spread over Europe.

Note, too, that of the 54 men who returned to Palos "a considerable number" sailed with Columbus on his second voyage a year before Charles VIII crossed the Alps into Italy and long before his army "broke



Christopher Columbus at the court of Ferdinand and Isabella

up" before Naples. How many are "a considerable number?" Perhaps half of Columbus' first-voyage crew went on the second voyage . . . leaving perhaps 25 or 30 men who must have been extremely busy to have spread so much syphilis in so short a time.

The military might of France gathered under Charles VIII at Lyons in south central France in the spring of 1494. The French king, nicknamed "Charles la Grosse Tête" or "the Fathead," was not only of surprisingly ugly appearance—with his enormous head, limber, too-small neck, low, squat figure—but he was both stupid and stubborn. Francis Hackett says of Charles in his brilliant biography of Francis the First—"he was perhaps not technically an idiot but to be three-quarters witted is scarcely enough."

Charles was on a grand adventure of the most adolescent sort, an escapade which nearly cost him his kingdom and which—far from making good his titular claim to Naples—united Spain, Germany and Italy as his bitter enemies.

The first of Charles' forces to move was an army under the Duke of Orleans, who set out in June, 1494, with 8,600 Frenchmen to occupy Genoa. This contingent never left northern Italy and was not involved in the medical woes which visited the French at Naples.

Charles himself set forth for Italy on July 27, 1494, with the main body of troops totaling 30,500 men by the time they entered Italy on September 8. Of these, 6,000 were Italian, 3,000 were German and Swiss and 21,500 were French. No Spaniards were listed among them. (Sea forces totaling 10,400 men set off for the Italian coast during the summer of 1494, but I have found no details regarding the composition of that body of men nor of their movements.)

An eight-day king of Naples

Charles reached Naples on February 22, 1495, after a triumphal journey and apparently joyous receptions everywhere en route. This "promenade militaire" consumed five and one-half months. He was crowned king in Naples on May 12, 1495, and eight days later he was obliged to flee for his life to escape being cut off from France by a coalition of the kings and dukes who had so recently "welcomed" him with Maximilian of Germany and Ferdinand of Spain. This coalition sought to trap and eradicate the French forces in Italy and divide up France.

Leaving his Italian, Swiss and some other units—a total of 12,000 men—in Naples, Charles covered in less than 60 days the distance which had occupied five and one-half months on the southward journey.

He took with him only the most dependable of the French troops. Charles' fate was in the hands of a few hundred knights and gentlemen of France (including that famous knight "sans peur et sans reproche," Chevalier de Bayard)—daring and expert fighters—and a body of *ultra-mountain* soldiers, men from beyond the Alps. About 8,000 of these reliable Frenchmen—1,000 Picards, 1,000 Normands, 6,000 Gascons and Dauphinois—marched into Italy with Charles and his knights. On his dash to break out of the trap so nicely set for him "la Grosse Tête" relied on these men to save him. His forces were not flying in disorder . . . they gave a good account of themselves in several battles before they reached home.

The forces left behind in Naples were less fortunate. They were attacked and many were killed in the streets. The French commander and viceroy withdrew from the city to Castello Nuovo. A Spanish fleet came and threatened him from the sea and he was besieged from the land.

"Fever" decimated his forces, and both the viceroy and King Ferrand of Naples, commander of the enemy land forces, died of this same "fever." Many men ran away to escape the disease or to abandon a listless campaign. Only a few—perhaps 1,500 of the 12,000 who had garrisoned Naples—remained or survived to be taken by ship to France when a truce was agreed upon on January 18, 1497.

Syphilis did not decimate Charles' army

Charles did not flee from Naples because of an "epidemic" of syphilis but because his rear, his base of supplies and France herself were most gravely threatened. The force with Charles was not disorganized, and it was healthy enough to fight well in several battles. The disease which killed off the garrison left by Charles in Naples was a "fever" . . . and the best guess is that it was typhoid fever, typhus or malaria. Almost certainly it was not syphilis.

Most members of Columbus' crew on the first voyage came from Palos and its port, Saltes. Many were family men with homes and children. The fact that "a considerable number" sailed on the second voyage, which also left from Palos, suggests that they had remained there while Columbus was at Seville and Barcelona arranging for the second voyage.

It is a long way from Palos in the south of Spain to Lyons in France—where Charles assembled his army—and the speediest method of travel at the time was muleback! It requires a severe stretch of the imagination to conceive how these few men—25 or 30 at most—who did not go with Columbus on the second voyage could have traveled on muleback from Palos to Lyons and infected so great a number of the camp-followers of Charles' army that syphilis became epidemic among the French troops and mercenaries gathered by Charles from all over western Europe.

Nor indeed is it apparent why they went, or were permitted to go, when their sovereigns, Ferdinand and Isabella, were the bitter enemies of Charles VIII and were supporters of Naples against the French claims. The King of Naples was Ferdinand's brother-in-law.

From March 15, 1493, the date of their arrival at Palos, to July 27, 1494, when Charles VIII and his main army moved from Lyons toward Italy, was a period of 16 months. In that time this handful of perhaps two dozen men are supposed to have tired of their role as heroes returned from a dazzling adventure, tired of talking about it in the taverns and on the docks at Palos, tired of their families, and to have abandoned Spain for France—which all Spaniards hated—and to have gone the great distance to Lyons. What for? They were sailor adventurers, not soldiers of fortune. The lists of Charles' hosts contained no Spanish units. It may be assumed there were none.

But if no Spaniards were in Charles' army, how did syphilis get over the Pyrenees so quickly? How did Charles' army spread syphilis on the way to Naples and back? Probably syphilis had been in Europe for centuries and was spread—as it was during World War II—by armies in passing or in occupation.

It is incredible

There may never be a final and conclusive answer to the question, "Is syphilis America's gift to the world?" Is the Columbian theory of its introduction into Europe the greatest calumny of medical literature . . . or is it the true story of appalling retribution for the wrongs done to the Tainos?

We do have some evidence that there may be another explanation for the reported outbreaks of syphilis at just this time. We know, for instance, that as the mysticism of the Middle Ages gave way to the vigorous realism of the Renaissance, men's minds turned from an almost exclusive preoccupation with their immortal souls to a study of the physical world around them. Certainly Columbus' voyage to the unknown West was one

demonstration of this new interest. Certainly the development of a thirst for learning, for facts, that marked the era was another.

May one not therefore hazard a guess that the recognition of syphilis as a disease with specific symptoms and sequelae was not the result of its having made its initial appearance in Europe at just this time but rather because the searchlight of the New Learning had been turned upon it? It is admittedly not as dramatic an explanation of the facts of the case as the Columbian theory but to this commentator, at any rate, it seems considerably more likely.

The Columbian theory is a better story, more dramatic, more imaginative and romantic. But it is too, too hard to believe.

Bibliography

Books

1. *Admiral of the Ocean Sea*, by S. E. Morison. Boston, Little, Brown and Co., 1942. One-volume edition. (Also two-volume edition.)
2. *Classic Descriptions of Disease*, by Ralph H. Major, M.D. Springfield, Ill., Charles C Thomas, 1945. Third edition.
3. *L'Expedition de Charles VIII en Italie*, by H. F. Delaborde. Paris, Librairie de Firmin-Didot et Cie, 1883.
4. *Histoire de France*, by H. Lemonnier. Volume 5. Paris, Librairie Hachette Cie, 1903.
5. *History of France*, by G. W. Kitchin. Three volumes. Oxford, Clarendon Press, 1898.
6. *The Medicine Man of the American Indian and His Cultural Background*, by William T. Corlett, M.D. Springfield, Ill., Charles C Thomas, 1935.
7. *The Northmen, Columbus and Cabot*, edited by E. G. Bourne. (Contains translation of Columbus' *Journal of His First Voyage to the West Indies* as abridged by B. Las Casas.) New York, Charles Scribner's Sons, 1906.
8. *Treponematosi*, by E. H. Hudson, M.D. New York, Oxford University Press, 1946.

Articles

1. Antiquity of Congenital Syphilis, by R. C. Holcomb, M.D. *Bulletin of the History of Medicine*. Vol. 10, July, 1941, p. 148.
2. Discussion of Yaws, by Sir J. Hutchinson. *British Medical Journal*, Vol. 2, Sept. 1, 1900, p. 561.
3. Disease, Medicine and Surgery among the American Aborigines, by Ales Hrdlicka, M.D. *Journal of the American Medical Association*, Vol. 99, Nov. 12, 1932, p. 1661.
4. The Drama of Syphilis, by C.-E. A. Winslow. *Journal of Social Hygiene*, Vol. 23, Feb., 1937, p. 57.
5. Geography of Treponematosi, by H. Hamlin. *Yale Journal of Biology and Medicine*. Vol. 12, Oct., 1939, p. 29.

THE SEXES IN A RESTLESS WORLD



by Chester North Frazier, M.D.

A talk given before the Massachusetts Society for Social Hygiene

The nineteenth century had come to a close. It was in the afterglow of this era, and near its end, that the Massachusetts Society for Social Hygiene came into being. In 1911, under the leadership of President Charles W. Eliot of Harvard and Bishop William Lawrence, the society was founded by a group of citizens concerned with the social welfare of the community.

Its purpose was "to promote a more rational attitude towards sex and a better understanding of its role in health and human relations."

The traditional attitude of the closing era as it related to sex was one of negation. To be sure, the existence of sex as a biological fact was not to be denied. Obviously there were men and women. And children bore silent witness to the function of the dichotomy.

Social proprieties, however, forbade a familiarity with the anatomical realities of being male or female and with the physiological manifestations of the anatomical differences. So reticent had we become that the proper names of the sexual attributes of the human body were unknown to our children and even the educated adult was at a loss to express himself adequately. Sexually we were illiterate, and for that matter largely remain so to this day.

It must have required no little courage on the part of our founders to have asserted frankly and publicly that this community needed some attention given to its attitude towards sex and to understand that both physical and mental health depended upon this knowledge.

Furthermore, it was recognized that this knowledge not only concerned the person as an individual but also his relations with others. Social hygiene was a matter of human health and human happiness.

Publicizing VD

The immediate concern of the society was the social diseases, syphilis and gonorrhea, words not to be spoken above a whisper and never to appear in print except in medical literature. In fact, it was not until 1927 that the proper names of the venereal diseases could appear in the newspapers and magazines of this country. At last the problem has become public knowledge.

As early as the first World War this society engaged itself in the campaign against the venereal diseases. Its work at that time was largely determined by the need for a medical program to combat syphilis and gonorrhea as a major problem of health in wartime.

This pioneering endeavor must bring satisfaction to the members of this society. From it and similar movements in this country the public at large has been made aware of the importance of these diseases to our national economy. Throughout the land, with the aid of private and public funds, there is a concerted attack against syphilis and gonorrhea. If this is sustained, it seems reasonable to expect a continuing decrease in the incidence and prevalence of these diseases in our population.

Thrice loved

Social hygiene comprehends more than the frontal attack on the venereal diseases. It is concerned with the relations of man and woman and with the understanding each must have of himself as a male or a female and the conjugal role each must play in life. And not least is it concerned with the living issues of the sexual union. Pope's *Essay on Man* emphasizes that

"Each loves itself, but not itself alone,
Each sex desires alike, till two are one,
Nor ends the pleasure with the fierce embrace;
They love themselves a third time in their race."

In 1928 the society was reorganized. Since then the emphasis of its program has been on education. This has taken two directions. It has provided information on the venereal diseases. Secondly, it has supported a program of sex education, the aim of which is to develop a healthy and rational attitude towards sex in all its physical, psychological and

social aspects, and particularly to help men and women towards successful marriage and parenthood.

Sex is not simple

The problems of sex, however one views them, are wide and complex. Anthropologists know how varied they are among different societies, how the problems of one people are not those of another people. Traditions and customs differ. Poets and philosophers have wrestled with the ideas surrounding sex and the relations between the sexes and the joys and sorrows growing from them.

Others have not overlooked the broader aspects of the success or failure of the relationship of man and woman and its effect on society in general. In the *Book of Rites* Confucius states that "marriage lies at the bottom of all government," and Macaulay thought that "the mutual relations of the two sexes seem . . . to be at least as important as the mutual relations of any two governments in the world."

The stinging barb

But there have been cynics too. Shelley in *Queen Mab* observed that "a system could not well have been devised more studiously hostile to human happiness than marriage." In the same vein Oscar Wilde, in *Lady Windermere's Fan*, has remarked that "the world has grown suspicious of anything that looks like a happy married life." Such were the pangs of pessimism.

In a gentler and lighter humor are other musings of the doubtful:

"Lo! here's the bride, and there's the tree;
Take which of these best liketh thee."
"The bargain's bad on either part—
But, hangman, come—drive on the cart."

There is a nursery rhyme:

"My little old man and I fell out.
I'll tell you what 'twas all about;
I had money and he had none,
And that's the way the row begun."

Rudyard Kipling has added a humorous note to the discussion:

"Now, if you must marry, take care she is old—
A troop-sergeant's widow's the nicest I'm told—
For beauty won't help if your vittles is cold."

And poor Richard wisely gave as his opinion:

"Where there's marriage without love,
There will be love without marriage."

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Chester North Frazier, M.D.



Still others would approach the problem more objectively. Cautioned Balzac: "No man should marry until he has studied anatomy and dissected at least one woman."

However, Balzac seems not to have accorded the woman equal opportunity. This may be another example of the double standard imposed by the male on the female. That which is sauce for the goose should also be sauce for the gander. It is not just, nevertheless, to place the entire burden of guilt on the male. Everyone should know that he is guilty enough. But the female is equally as responsible frequently for the dilemma of sexual ignorance.

Begin at the beginning

Where to begin educating for the adjustments of life presents its difficulties. There is an old Greek proverb which says that "it is useless to physic the dead or to advise an old man." The pattern of adult behavior is surely based upon childhood experience. The infant at the mother's breast must learn that it is either of the same or opposite sex from the mother who has borne it or the father who has fathered it. As it grows older, it can but reflect in its own attitude toward its sex or its opposite sex the attitudes of the parents.

Conditioning begins early in life. It is not unreasonable to believe that by the time youth is adolescent the pattern of its reaction to the matters of sex has been largely fixed. The young man or young woman will be fortunate indeed if by the time he or she has attained a marriageable age his attitudes towards sex are not fixed in a mold no longer malleable. The task of the counselor is then difficult.

But however difficult it may be, the responsibility is present. There are those who would be shown the solution of their problems. Some insight into the truth, while it may not benefit greatly those who seek it, may be the means of starting the next generation on a more understanding and less frustrating life.

Pedigrees are for dogs

It is indeed a fact to ponder, as Charles Darwin has remarked, that "man scans with scrupulous care the character and pedigree of his horses, cattle and dogs before he matches them; but when he comes to his own marriage he rarely, or never, takes any such care."

As we consider the problems with which this society is engaged, there can be no room for fatal pessimism. It would be well to recall the thoughts of one of our early neighbors in Concord, Henry D. Thoreau, when he contemplated the slow pace at which human beings move: "You can hardly convince a man of an error in a lifetime, but must content yourself with the reflection that the progress of science is slow. If he is not convinced, his grandchildren may be."

Nature study

by Whitney Darrow, Jr.



"Pop, there's something you didn't tell me about the bees."

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FRANCE VOTES NO

Blocks Efforts to Reopen Brothels

by Jean B. Pinney

Early this year wide publicity was given to a startling proposal by Mme. Marthe Richard, a member of the French National Assembly and sponsor of the French law which closed the nation's brothels in 1946. Completely reversing her stand of six years ago, Mme. Richard now announced her conviction that the law had been a failure. Furthermore, she would undertake to get it repealed and new legislation legalizing prostitution and medical inspection of prostitutes adopted.

Among the unfavorable results of the 1946 law, she claimed, were increases in the venereal diseases and in clandestine prostitution.

Health and social protection workers, including those of the United Nations—which in 1951 had invited the nations to subscribe to a new international convention against prostitution—were naturally disturbed at this proposed retreat by a chief ally in the campaign against vice.

Finding the facts

In the United States, the American Social Hygiene Association was called upon by its members and friends to get the facts and make them known. In France, the French League against Venereal Diseases (a national member agency of the International Union against the Venereal Diseases), the French Association for Suppression of Traffic in Women and Children, and other interested groups put accurate information before the legislators and the public.

The results were as might be expected when determined, well-organized effort is made in such matters . . . the proposed legislation to repeal the 1946 law was flatly rejected.

They voted against reopening

Developments, as reported by our European colleagues to the American Social Hygiene Association's division of international activities, are interesting:

- As recommended by Mme. Richard, early this year two measures were introduced before the French National Assembly, one by Senator Jean Durand, the other by Dr. Mazuez. Both bills called for repeal of the 1946 law and for legalization of prostitution, medical inspection of prostitutes, and reopening of the brothels.

- French experts on health and social welfare promptly pointed out the fallacies on which the proposed legislation was based. VD, they pointed out, was steadily declining, not increasing, under the attack of medical and public health efforts. Medical inspection of prostitutes as a protective health measure is impracticable and ineffective. Clandestine or streetwalking prostitution is indeed prevalent in Paris and elsewhere in France . . . but when was it not?

Reopening the brothels would not solve any of these problems, and the repeal of the 1946 law would be a definite backward step in efforts to safeguard the homes, health and welfare of France.

- On February 20 the Assembly's 32-member committee for family, population and public health, which must approve all health and welfare proposals before legislation is submitted to the Assembly, voted unanimously (two members abstaining) to reject the Durand and Mazuez bills and to give the same treatment to any future proposals which might lead to the brothels' reopening.

It is also reported that a special Commission of Inquiry is being appointed to look into the operation of the 1946 law and consider needed improvements in this legislation.

So ends a brief but important battle in the long war against an old and still well-entrenched evil. That the forces opposing it in France are alert, informed and well able to press the attack is shown by some of the statements made by various authorities and experts during the skirmish, among them Dr. André Cavaillon, for many years director in the French Ministry of Health and since 1923 secretary-general of the International Union against the Venereal Diseases.

VD and the brothels

In an article in a French periodical Dr. Cavaillon says, "The venereal diseases, and particularly syphilis, are in the process of disappearing in France. Syphilis was on the way out before the war began in 1939. There was an increase from 1940 to 1945, due to the dislocations of war, the occupation and the liberation, but the figures show a steady decrease since then. The increase occurred while the brothels were operating; the decrease occurred while the brothels were closed. The truth is that the brothels cannot give any health protection. . . .

"As for the medical examination of prostitutes, all medical men know how difficult it is to say positively that a woman is not infected, let alone

the difficulties of proper inspection. (The American Medical Association and state medical societies have repeatedly condemned the practice of medical inspection of prostitutes and have affirmed the difficulties mentioned. See the JOURNAL OF SOCIAL HYGIENE for January, 1946.) In a town in France that I could name the medical examination of prostitutes used to take place at the rate of three girls per minute, and the use of modern laboratory techniques was entirely unknown.

"In a certain house in Paris, the outbreak of a syphilis epidemic once revealed the fact that six of the 60 women inmates were suffering from infectious lesions, although they were all under regular medical inspection. A thousand men per week were in contact with these women, with many weeks going by before the flood of new syphilis cases brought to light the failure of the 'official control' of health conditions in the house.

"It is nonsense to base the campaign for reopening the houses on the plea of reducing the venereal diseases," the Cavaillon article continues. "And what a paradox to try to base it on morals! The brothels as guardians of morals and manners! They are in truth schools of prostitution, centers of debauchery, where begins the training of new recruits—the process which slowly transforms the innocent young girl into a professional prostitute.

What about the streetwalkers?

"Nor can the theory be taken seriously that closing the brothels has caused an enormous increase in clandestine prostitution, as claimed by



*Streetwalking
can be
eliminated.*

the proponents of repeal. This theory merely indicates a lack of knowledge of the past. The houses were not closed until 1946. Is it seriously believed that there was no 'streetwalking' prostitution in France before then?

"The same argument has been advanced before. For example, long before the war began in 1940, when certain communities—among them Grenoble and Strasbourg—closed their brothels, interested parties hastened to declare in widespread publicity that clandestine prostitution was becoming a shame and a scandal in these towns. But these shocked persons made no mention of the huge amount of clandestine prostitution which at the same time existed in Marseilles, in Lyons, or in Paris, where brothels then were particularly prosperous.

"This is not to say that the problem of clandestine prostitution in France is not a serious one. It is to say merely that this problem has nothing to do with opening or closing the brothels. Prevention of 'streetwalking' prostitution is simple. It is only a matter of making up the municipal mind to enforce the laws against it, as is plain from the fact that some communities are free from this evil, while in others prostitutes constantly and openly accost passers-by in a manner far from clandestine.

"It is a sad story, indeed, but the whole idea of solving the problem by opening the brothels is a joke.

Improvement of the law

"The 1946 law against prostitution is not perfect. It ought to be improved. Since the debate has been opened, now is the time to correct a number of the law's faults. We would be happy to see the appointment of a Commission of Inquiry, as proposed to the Parliament, and believe that the results of such an inquiry might shed considerable light."

Testimony in support of Dr. Cavaillon's arguments is offered by Professor Paul Gemaehling, a member of the faculty of the Paris School of Law and vice-president of the International Abolitionist Federation at Geneva. In a pamphlet published in 1950, *Bilan d'une Reforme*, he quotes statistics from the National Ministry of Health showing that the prevalence of gonorrhea dropped from 63 cases per 100,000 population in 1947 to 52 cases per 100,000 population in 1949. Syphilis decreased from 29 cases per 100,000 in 1947 to 11 cases per 100,000 in 1949.

Professor Gemaehling also attests that the number of streetwalkers in Paris, while indeed large, is nothing like the 30,000 to 35,000, or even 100,000, alleged by some irresponsible persons and played up by the sensational press. Figures furnished by the director of health to the Prefect of Police early in 1950 showed 3,500 women registered at the Fichier Sanitaire, a bureau set up following the passage of the 1946 law.

The health director said at the time of making this report to the Health Council of the Department of the Seine, "I seize this opportunity to enter a protest against the sort of exaggerated statement which has been made publicly regarding this situation. It gives the whole Parisian people a bad name to the rest of the world and to visitors coming here."

Public opinion

It has been suggested that Mme. Richard, in launching her campaign against the law which she herself sponsored in 1946, was misinformed as to its effects or that she may have been led to unwise tactics as a means of advertising her recent book, *L'Appel des Sexes*. Some Europeans have thought she is being exploited by the prostitution interests. Whatever her motives in stirring up this controversy, it is plain that the closing of the brothels has met with general approval in France and that public opinion is against their reopening.

This is in accord with the prevailing sentiment in many other nations as expressed through the new International Convention for the Suppression of Traffic in Persons and of the Exploitation of the Prostitution of Others, adopted in 1949 by the General Assembly of the United Nations. This Convention, in process for nearly two years, was drafted by the United Nations Social Commission in consultation with governments and in collaboration with nongovernmental organizations, including the American Social Hygiene Association, International Abolitionist Federation, and International Union against the Venereal Diseases.

Stating in its preamble that "prostitution and the accompanying evils of the traffic in persons for the purposes of prostitution are incompatible with the dignity and worth of the human person and endanger the welfare of the individual, the family and the community," the convention extends and unifies four existing international instruments adopted by the League of Nations from 1904 on and includes provisions of a draft convention proposed by the League in 1937.

Convention terms bind signatory governments to punish brothel-keepers, landlords and financial backers of houses of prostitution. It gives alien victims the same rights as nationals. It makes offenses extraditable and requires abolition of the registration of prostitutes and suspected prostitutes.

A positive position

It differs from earlier agreements in that their operation was confined to police action to prevent and punish traffic in women and children, while the new convention obliges signatory states "to take or encourage through their public and private educational, health, social, economic and other related services, measures for the prevention of prostitution and the rehabilitation of the victims of prostitution."

*Long-time editor of the
Journal of Social Hygiene
and now consultant on
ASHA's international activities.*

Jean B. Pinney



The UN secretariat opened the new convention for signature by any nation, whether or not a member of the United Nations, on July 21, 1951, and it is now in the process of circulation. France is among the countries not yet signing, but her 1946 law embodies many of the international convention's provisions.

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BOOK NOTES

by Elizabeth B. McQuaid

For Better or Worse, by Morris L. Ernst and David Loth. New York, Harper, 1951. 245p. \$3.00.

Much sound social and legal wisdom regarding domestic problems, divorce and subsequent adjustment is contained in this book by two experts, one from each branch of the trade. Mr. Ernst, a lawyer of more than 30 years' experience in handling such matters, and Mr. Loth, a publicist and an official of a social agency concerned with marriage counseling, combined their talents and practical experience with the learning of their professions to produce what may well be regarded as a handbook for both lawyers and social workers particularly interested in dealing with family difficulties.

The book's charm is in its down-to-earth practicality, forged on the anvil of the experience of these men. A somewhat singular and effective feature is the stories of people (fictitious names, of course) who have actually been through the mill, telling their reactions, satisfactions, regrets and adjustments in first person.

It is recognized that the disintegration of family solidarity is one of the most serious threats to western civilization, at least rivaling if not out-ranking world politics and the atomic bomb as a problem to be solved.

The waste in human potential—moral, social, economic—is incalculable.

Special attention is given to the children who as innocent bystanders are the greatest casualty. It is pointed out that 300,000 per year, a total of three to four million children in our population, are victims of the divorce rifts of their parents. The evil effects of this situation—distorted personalities, instability of character, juvenile delinquency, crime—ramify throughout our society and make for a continuing similar pattern in succeeding generations.

The authors are not content with mere calamity-howling. They believe that by letting down the bars and eliminating the subterfuge, fraud and pretense which present legal requirements and social attitudes force upon the parties, the lure of divorce will be lost and the family unit strengthened. In collaboration with proper social services, courts should do a really thorough job instead of following the present system in which 95% of the cases are a "cooked dish" ready for consumption before the court

ever sees it so that he merely rubberstamps the arrangement which the lawyers and the parties have agreed upon.

The proposed cure? Roughly, less legal ritual and formality, a forthright recognition of realities. In childless marriages, a mere ascertainment that the action is not ill-considered or hasty and that neither party is imposed on in the settlement. Where there are children, the same, only more of it.

The goal? Fewer but better divorces. And we agree with the authors that this goal "should be the one set up by all those who would reform divorce laws. It should also be the goal of those who argue for keeping them the way they are."

For the social-minded: good reading. For "commercial artists" of the divorce business: anathema.

The Honorable J. Allan Crockett
Justice, Supreme Court of Utah

Men, Women and Morals, by Sylvanus M. Duvall. New York, Association Press, 1952. 336p. \$3.75.

Much water has flown over the societal dam during the half-century that has elapsed between the insipid sex writings of Sylvanus Stall and the incisive ones of Sylvanus Duvall. The latter, who is professor of social science and religion at George Williams College, depicts the resulting changes authoritatively, provocatively and graphically in this newest of his contributions to a better understanding of the sex factor in life.

The current volume seeks to evaluate present and past codes of sexual conduct and to measure their wisdom and validity when viewed as vital factors "in the larger context of sociology, philosophy, ethics and religion." The author's success in achieving this type of impartial inventory will, result, we believe, in rather decided lack of enthusiasm for the book by extremists in both categories, i.e., orthodoxy and radicalism. Of the two, the radicals probably will disagree with more and appreciate less of the contents.

In chapter 3, Dr. Duvall defines morality in essence as dealing with "behavior which benefits or harms people." And in chapter 15 he cites his belief that unless the principle "that men have moral obligations" is accepted, "all attempts to establish a sex code will prove futile." He warns also that "the concept of moral obligations must be reestablished with each generation."

Social hygienists—be they teachers, preachers or parents—will find reams of excellent discussion points, pithy facts and hard-hitting dialectic

in each of the 16 chapters, with an added dividend in the "Manifesto on Sex Standards" (pp. 311-313). Take chapter 12 for instance. It is entitled, "The Morality of Prostitution," and the author, after doing a nice job of demolishing numerous ancient and specious arguments favoring the institution, declares, "It is ridiculous to pretend that commercialized prostitution is anything other than what it actually is—a type of socio-sexual cannibalism."

The book is well indexed and solidly documented, and carries an extensive bibliography. Above all, it is both an altruistic work and one which has the inestimable advantage of being readable *per se*.

Ray H. Everett, Executive Secretary
Social Hygiene Society of the District of Columbia

Current Therapy 1952, edited by Howard F. Conn, M.D. Philadelphia, Saunders, 1952. 849p. \$11.00.

For directions on non-surgical modern treatment of practically every disease to which humans are subject—from amoebiasis to spider bite—consult Conn's *Current Therapy 1952*. Seven well known authorities wrote Section 9 dealing with the treatments of the five venereal diseases. Their directions are brief, specific and conform to modern standards. A remarkably good index guides one to precisely the information desired.

Charles Walter Clarke, M.D.

Marriage, by Herman J. Peters. Palo Alto, Calif., Pacific Books, 1952. 112p. \$1.50.

This topical outline for a college course in marriage and family relations was written by an associate professor of psychology at Chico State College, Calif. Each unit consists of a list of objectives, discussion topics, assignments and selected readings.

Included among the topics outlined are *Life in the Parental Family*, *Courtship Factors—Careers for Women*, *The Direction of Marital Conflict* and *Religious Living in the Family*.

Various forms are provided which students may fill out to evaluate their own personalities as related to premarital and married life: a personality rating scale, an adjustment inventory, a courtship scale, a marriage prediction schedule, a marriage adjustment schedule. Lists of organizations and services and a bibliography complete the outline.

KANSAS CITY, MO.
PUBLIC LIBRARY

NOV 19 1952



journal of SOCIAL HYGIENE

vol. 38

november 1952

no. 8

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About our cover . . .

Queen Elizabeth II with the Duke of Edinburgh and their children, Prince Charles and Princess Anne, in the garden at Clarence House. Seventeenth of a series of Journal covers on family life . . . photograph courtesy of British Information Services.

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THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

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Let's Give Parents Security

A call for cooperation among experts

by Grace C. Mayberg

Some of the confusion and insecurity that seeps through to every layer of our living today wells up and expresses itself in our lack of confidence in our roles as parents, husbands and wives, young adults and older persons. In all settings, social and professional, we hear this uncertainty expressed . . . "I've tried to be a good mother, I don't know how successful I've been." "I wonder if my working outside the home has made my husband feel less important and has contributed to our trouble."

This uncertainty has its strengths in that it implies a desire to be different, more adequate. At the same time, it accounts for some of the pendulum swings in behavior that are so confusing in all relationships as one thing after another is tried out.

Technique or confidence?

Experts with the best of intentions have done nearly as much to contribute to this uncertainty as they have done to relieve it. Pediatricians in the 1920's and 30's tried to make social workers out of mothers by teaching conscious applications of techniques instead of helping them to develop confidence in themselves in their new roles.

Speakers have threatened mothers and fathers by talking about the security children must have from parents to grow into happy adults and useful members of society. Listeners, because of their own feeling of inadequacy, have drawn perfectionistic inferences which were not intended.

Maybe we who are engaged in family life education are going to have to begin with the assumption that the people we talk to are doing a pretty responsible job, and to see our role as a means of helping them to build on their strengths as individuals as well as members of families.

A prominent psychiatrist once told me that in working with neurotics his beginning treatment was based on the premise, "You're all right as you are." With that basic reassurance they could bear to face the things about themselves that they wanted to change.

Keeping our sights

Our driving culture increases our expectations of ourselves. With articles in magazines constantly conjuring up the perfect hostess, the beautifully operated home, the charming and gracious wife, the resourceful, understanding father, we are placed in a competitive situation with an imaginary rival. Think of what that does to our feelings of adequacy!

We who are attempting to help persons find more satisfaction in their roles can have as a common base a real acceptance of persons as they are, as well as an acceptance of the fact that people who want to improve in a particular part of their life should not be made to feel inadequate in their whole life. By attending our lecture, reading our pamphlet or participating in our discussion series they are exhibiting an interest in improving relations with their families or in getting more satisfaction out of their own roles.

The non-specific request

Family agencies have been attempting to find the way in which case-workers can make the most effective use of their knowledge and methods in this shared educational effort.

Requests come in a diffuse, undifferentiated manner as communities are learning how to use us, just as we are learning how we can best be used. A school asks for a speaker on "something about the mental hygiene of the family" . . . a leader of a Y-teen club telephones for a group leader for a specific evening and inquires, "What subjects do you talk on?" As one member of the Family Service Association of America's committee on family life education put it, "We are all used to being worked in on the program between the coffee-and-doughnuts and what shall we choose for our state bird?"

Actually, we have outgrown this earlier tendency to accept every request for disseminating information about family life. We know now that careful preliminary exploration about the group—what it wants, whose idea this specific request was, whether they are interested in the discussion method—are important to the success of a meeting if our aim is that something more will come out of it than passive listening to information or entertainment.

In trying to meet the symptomatic requests for information around family life, many community agencies do not explore what these requests mean in terms of what the group really wants. These agencies not only

*The neurotic
is first
assured that
he's all right.*



lack sufficient information about others who are doing the job, but fail too to cooperate with them.

Shared thinking

Most family agencies believe that the most effective medium for making the knowledge and methods that are a part of family case work available to larger numbers of people in all segments of the population is the discussion group.

In a small, homogeneous group of 10 to 20 members, individuals are helped to discover blind spots in their relationships which make them unable to act appropriately. They are helped to examine their own attitudes and expectations and to understand and evaluate the stresses and strains within their homes as well as those on the outside.

Our experience indicates that groups do not gain as much from us from speeches or question-and-answer periods following lectures as they do when they become sufficiently involved to share their thinking and feelings about common problems. Through exploring situations, they have a better understanding of their own needs and of the feelings of the family members with whom they are involved.

The natural disappointment that accompanies the knowledge that they are not going to be given specific advice or a set of rules is minimized as they take hold of this method of exploration.

Understanding blots out tension

A common concern in mothers' groups is the difficulty of getting children to go to sleep at night. When they consider why this problem bothers them, what their fears are, why a child behaves the way he does,



*A real-life wife
finds herself
competing with
the eternal charmer
of an ad-man's
imagination.*

what their response is, and how the child reacts to it . . . when this is repeated in other situations they begin to see the effect of action and reaction. Instead of focusing on the child's problem-behavior or their own inadequacies or mistakes, they begin to gain insight into some of their struggles in relationships.

As they begin to feel more comfortable it is not so necessary for them to resort to rigid disciplinary measures nor to capitulate in desperation to the dominance of the child. It becomes easier for them to be consistent and reassuring as they set the reasonable limits for which the child is really asking.

In a discussion group the caseworker, recognizing the necessity for people to contribute to the solution of their own problems, uses her knowledge and skill to help them find ways that are right for them. She helps them to integrate and make more meaningful information they already have. She adds content geared to what the group wants. Her real acceptance makes it possible for those members needing more intensive help to go to the family agency for individual counseling.

People are more than parents

I find myself talking of parent-groups when it is true that family agencies over the country are not confining their efforts to parents alone. However, it seems that a greater number of caseworkers feel more certainty about their material and are more effective in group discussions where the normal development of children from birth to adolescence and the relationship of parents and children are the subjects under discussion.

Some premarital groups and groups of married couples have questions about sexuality that can be better met through individual help or group psychotherapy.

In Minneapolis, where we have put a great deal of time and effort into understanding the needs of older persons and into developing services to meet those needs, we have been interested in meeting with groups of adults who are responsible for older relatives, as well as with older persons themselves.

I mention this because I think that each agency should attempt to find its own area of greatest competence, both as to setting, method and content. A great many people in every community are interested in better mental and physical health and increased opportunity for families. A large group of both governmental and voluntary agencies and organizations carry on this work. No one discipline has a corner on this responsibility. It is shared jointly by psychiatry, education, the ministry, case work, group work and many others.

(Editor's note: Since social hygiene draws on all these fields, a social hygiene committee in a Council of Social Agencies is an ideal medium through which they can coordinate their efforts for maximum effectiveness and minimum overlapping.)

Wider horizons

The *Social Work Year Book* for 1951 comments that "family life education, which began 62 years ago as an effort of a small voluntary group, has grown in function, scope and extent of activity until today it constitutes a major movement throughout the country."

The yearbook points out that today there are "a great variety of programs" including:

- High school and college courses in marriage and family living
- Homemaking education
- Programs for children, youth and adults
- Parent education and child study groups
- Programs of marriage counseling, social hygiene and mental hygiene, of both an educational and clinical nature.

The American Social Hygiene Association—with a program predicated on *prevention*—has made a marked contribution to the development of this important field of service.

As we in the various professional fields tell each other where we think we can be most effective in family life education, we can be less self-conscious and less critical about the differences in our methods and less concerned about the exact setting in which sharing of knowledge takes place. Unfortunately, we are not so perceptive as we should be about the advantages each setting affords.

How effective are we?

To alleviate our uncertainty we need to analyze and evaluate our own programs and attempt to face honestly how we can make the most effective contribution in this field and share these findings in discussions with each other.

We recognize that people learn in a great many ways. We listen to publicity experts who tell us that people no longer read for information and that radio and television are the primary instruments for disseminating information today. We could question this statement perhaps, but how much do we really know about the effectiveness of our methods, whatever they are? We need to be tireless in our effort to evaluate results of service and not be content with statistics giving numbers reached . . . even though we know that measurement of change of attitudes is difficult to gauge, particularly in a program where prevention is the important goal.

We need to ask questions such as "What are the differences in preventive programs in which physical health is the concern and those in which emotional well-being and better family living are the goal?" We need to learn more about how we can supplement each other's work in our interdisciplinary approach to family life education.

Too great a diversity

Work, study and research have been concerned with pathology and personality problems in family relations rather than with the normal. What material there is about the normal is scattered and varied in criteria so that there is a wide divergence in what the community receives as family life education. While I am not suggesting that we can all standardize the material we share, we have a grave responsibility not to contribute to the uncertainties that face families today.

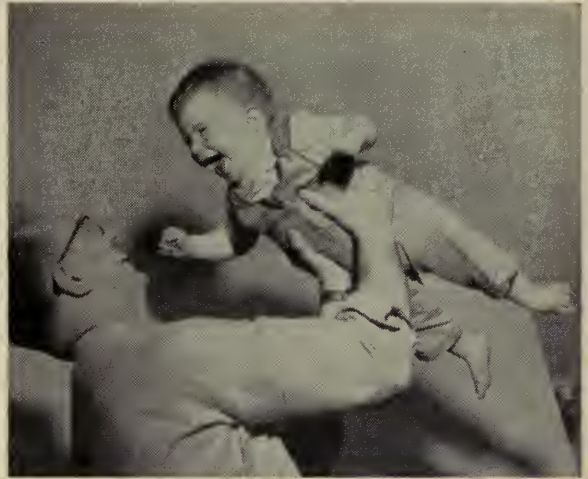
Individually as persons and as representatives of our particular agencies, we feel quite humble, I am certain, about having all the answers. Let us be sure that our uncertainties can be faced honestly and shared with each other for this important task we have undertaken together.

*University of Minnesota graduate.
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Once headed the Family Service Association's
committee on family life education.
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Minneapolis Family and Children's Service.*

Grace C. Mayberg



*A comfortable
father
is a
reassuring
father.*



Recently in Minneapolis we met together for the second time within a year at the University Center for Continuation Study in an all-day institute on family life. The Minnesota Council on Family Relations, which had had abortive beginnings over the last few years, had never really taken hold until, for the first time, a feeling of "togetherness" manifested itself at this institute. I don't know whether the presence, as moderator, of the benign, warm, accepting Msgr. John O'Grady of the National Council on Family Relations accounted in part for the change.

Educators, sociologists, doctors, nurses, social workers, ministers, lawyers, PTA leaders and others told of their experiences in family life education.

Upholstering for parenthood

I was particularly impressed with a thoughtful PTA president who could admit in a group of experts that an adult education class in upholstering had been her most profitable recent experience in parent education. The upholstering teacher, himself a father of adolescents, chatted about tying springs so that adolescents could plunk down on them in their characteristic way. The class pinned, nailed and stuffed . . . and talked earnestly of what it meant to be the parents of adolescents. And they felt they all gained by their sharing.

I am certain that the PTA leader gave us all reason to pause and think when she added, "And we weren't scared by experts."

Let us be sure that we who are experts can be content not to exploit our knowledge but to share humbly these things we know and feel. If we can help to bring new confidence and security to individuals and families, we will be making our contribution towards a world that can bear to look ahead.



*19-year-old student at New Mexico State College.
Social science major and journalism minor.
Editor of the college newspaper.
Plans a journalism career.*

Getting or giving in courtship

A teen-ager applies the golden rule

by Norval D. Glenn

What is right and what is wrong concerning our relations with the opposite sex?

This is a question of immediate and vital importance to us of the generation that is now in the last stage of adolescence and going into adulthood. We are in the stage of intense dating and courting . . . ahead of us lies the prospect of marriage. I think it is safe to presume that the opposite sex is the most important single consideration in the lives of all normal persons of late high school and college age.

And this is not only one of our most important problems . . . it is also one of our most difficult ones. The majority of us won't necessarily solve it successfully. The frequency of divorces and unhappy marriages among those of the generations preceding ours demonstrates that it is a problem capable of throwing people to bitter defeat.

And our future?

Are we going to solve the problem better than those who were our age five, ten or twenty years ago? This question is the subject of much current speculation and comment. I certainly hope that we can.

But the confusion and diversity of practice and opinion concerning sexual matters among those of my generation are not encouraging. I know few people who have definite ideas on sex morality which they live by and trust are right. Most of my college acquaintances who I have heard discuss the problem frankly admit that they don't know what behavior is best in courting and dating.

“Many articles on the subject of sex morality are appearing in periodicals now, but I have noticed that discussions written by us of the younger generation are almost never published. Perhaps we have some intelligent, sound ideas which deserve to be heard.”

But why are we of this generation confused about a subject about which we should be enlightened? We have grown up in a time when sex has been frankly and frequently discussed, when it has been the most popular subject of magazine articles, and when it has been given the interested attention of educators, clergymen and our parents.

Since we can first remember we have been told that some actions are right and others wrong. Parents, Sunday school teachers and others have made distinctions for us between good and bad behavior with persons of the opposite sex. We have read dozens of magazine articles on the subject and some of us have had sex education in high school or college. We know what society considers “respectable” conduct.

Why, then, can't we build an intelligent, workable code of ethics to guide us?

Challenging Codes

The answer can be found in a critical analysis of the type of instruction and advice our elders have given us. They have given us many rules of conduct and have expected us to accept them without questioning their value. Most of us did accept them during childhood and early adolescence.

But by the time we entered our late teens we had begun to be more independent in our thinking. We were no longer willing to accept our elders' advice merely because we trusted that they knew best. We wanted to know the reason for their rules of conduct. We wanted to know what basis their moral ideas had.

Now here is where the trouble lies. Most of us have failed to find a satisfactory basis for the distinction between proper and improper actions which respectable society imposes on us. The line between right and wrong seems to be arbitrary. A kiss is wrong on the first date but all

right on the third, we are told. Sexual intercourse is wrong before marriage but right after a formal ceremony. But why? we ask.

Why?

Sometimes our elders have tried to explain why. Rarely have they satisfied us with their explanations.

Frequently they have told us that certain moral restrictions are God's will, for example. But we believe that God is a rational being. We believe that His will, more than anything else, must have a purpose. Mortals might give us rules for no good reason, but God would not. And since we believe that we are as capable of knowing what is God's will as anyone, we still find ourselves asking why.

And what do we do if we keep asking why and can find no answer? By what do we guide our actions? The answer is, of course, that we have nothing definite to guide us, and this is why we are confused. Even the moral rules which society has given us are very indefinite, we find, if we try to follow them out of blind faith in their worth.

A wavering line

The line between right and wrong is somewhere between the obviously bad and the unquestionably good, but there is no general agreement on just where it should be. One person arbitrarily draws the line here and another arbitrarily draws it somewhere else. Our parents tell us one thing, our school teachers tell us something else, and the magazine articles don't agree with either of them—nor with each other.

There seems nothing for us to do but to get into the act and draw ourselves an arbitrary line to live by.

We may at first draw our line somewhere near to the one drawn by our parents. We usually move it later to make it nearer to the ones drawn by our teen-age acquaintances or to make it more convenient to live by. But what difference does it make? Where it is doesn't seem to be really important.

The girl is the arbiter

The result of all this line-drawing is a hodge-podge of unstable moral ideas among our generation. The opinions of the boys in my dorm concerning how far they should "go" with a girl on a date are probably typical of the diversity of ideas. The opinions vary from "all the way" to "no further than a kiss." The only opinion on the subject which several hold in common is the belief that it is all right to "go until the girl says stop."

Sex morality, I find, is regarded by many as something which changes like fashions and styles. Many times I hear the remark that something

*The opposite sex—
magnet and dilemma—
it's of interest
to all normal youth.*



“that used to be wrong” is “all right in this day and time.” A friend of mine who is a clergyman’s son recently said to me, “I’m out to get everything I can. And why not? Everybody is doing it these days.”

The unchanging moral principle

Obviously, what we need is a strong, timeless basis for our rules of sexual conduct. We need the same basis for our code of sex ethics that those a dozen generations before us needed and that those a dozen generations after us will need. Only the means of applying this basic principle should change to conform to the conditions of the times.

And is there such a basic principle? Surely there is. It is the same principle by which we should govern all of our actions. The sexual phase of our lives isn’t independent of and unrelated to the rest of our lives, although many seem to think that it is.

The idea that “all’s fair in love and war” seems to be prevalent. For this reason, many people have the idea that their conduct in courting

and mating is exempt from the application of this principle which is recognized as the ideal guide for human conduct.

Forgetfulness of self

The principle I refer to is partially stated in that lavishly quoted, seldom followed advice, the Golden Rule. It is the very heart of Christianity. Christ taught and practiced it throughout his ministry. It is the idea that virtue consists of putting the welfare and happiness of others above all else in the world, including selfish pleasure. It is the idea that the only good life is the unselfish one, the one that is lived for others rather than for self.

As I have said, this principle is the one that should guide the sexual aspects of our lives as well as all other aspects. Therefore, we should start with the rule, "Do unto others as you would have others do unto you," and make all our rules of conduct concerning our relations with the opposite sex harmonious with this basic one.

Only one question

When we accept the Golden Rule to guide our actions, we may forget all other rules we have been taught. We should forget all of the lines people have drawn between right and wrong. When we need to judge whether an action is good or bad, we should only ask, "Is it unselfish or selfish?" Whether it is respectable or not respectable, popular or unpopular should make no difference in our judgment of its virtue.

The selfish-unselfish method is an unchangeable criterion. It is the only sane method of determining ethical sex practices. And yet it has been neglected or referred to only indirectly in most of the discussions, lectures and articles on sex morality to which we of my generation have been exposed. Much of the advice given to us may have been sound, of course. Its main weakness has been its apparent lack of reason and basis.

Using an unselfish attitude as a basic characteristic, let us determine the outlines of a virtuous sex life for a young person of today. Then we may see how near to right our elders' advice has been.

To give happiness

First, what should be our aim in all of our relations with the opposite sex? Since it must be an unselfish aim, the satisfaction of sex desires, the strengthening of ego, and the gaining of prestige or social position must be ruled out.

The fact that these selfish motives are dominant in the courting and marrying of today is responsible, I believe, for most, if not all, of the frustration and unhappiness that frequently accompany these relationships. The giving of pleasure, happiness and well-being to the partner

*Not what elders say,
but the reason for it.*



in the relationship is the virtuous primary aim of any date, courtship or marriage.

Let us start with the most simple formal relationship between the sexes, the first date, and take a close-up view of the best conduct.

The first date should have two aims, both unselfish. I have stated the first one already. Giving the date a good time should be the primary consideration. The boy should feel he is responsible for the happiness or unhappiness of the girl during and resulting from the date . . . and vice versa. He should try to make her feel at ease, forgetting his own self-consciousness, and give consideration to other small but important things. The girl should do the same.

The boy shouldn't attempt to kiss the girl during the date. There hasn't been time for affection to grow up between the two. The only reasons the boy will have for getting a kiss are to get a sexual "charge" from it or to build his ego as a Romeo. A kiss should never be *gotten* by the boy on any date, first or fortieth . . . it should be *given* as an expression of affection.

A time for winnowing

The second aim of the first date, although it may not affect the partner in any way, is unselfish because it will help bring about the happiness of the one whom the person finally chooses to be his or her life partner.

A first date is an opportunity for a person to know a different type of person from those he (or she) has dated before. Thus it helps one to determine what kind of individual is best suited to be one's marriage companion. This is of major importance to an unselfish person because he cannot hope to give the most in happiness to a mate who doesn't have interests, likes, habits and attitudes compatible with his own.

The same aims and standards of conduct that are best for the first date are also best for all dates while the individual is "playing the field." He should always do his best to make his date enjoy the time they spend

together, and without effort he will give his partner and himself valuable experience to use in their selection of a mate.

If a couple find that they are not suited to each other after a few dates, the wise thing for them to do is to stop dating each other. The one who realizes the incompatibility first should stop the dating because he or she realizes that it is best for both of them.

When to go steady

Then what about the relationship of a couple after they "fall" for each other? What is right after a boy and girl stop playing the field and start "going steady"?

First of all, they shouldn't begin going steady until each of them begins to feel that maybe the other one is "the one" for him or her. They shouldn't consider going steady unless they enjoy being with each other very much and have begun to understand and have a genuine interest in each other. Going steady with someone merely because he or she is a "good catch" is foolish.

A person is more responsible for the happiness of someone he dates steadily than he is for someone he dates only occasionally. A couple going steady should realize that what each of them does has an all-important effect on the happiness of the other. A boy shouldn't consider what he will have more fun doing when he is with his steady girl friend . . . he should only consider what she will enjoy most.

He should never try to make her jealous or make her feel that she is constantly in danger of losing out to a more glamorous rival. A boy



*They don't know
what dating behavior
is right or wrong.*

(or a girl either) who does anything like this is trying to get the girl to try harder to please him, and this is a selfish motive.

What about kissing?

Kissing is natural and unselfish between a couple who begin to feel affection for one another. Sexual feeling cannot be entirely absent, but it should be dominated by unselfish interest in the well-being of the other person. It is inconceivable that a boy who parks with his date and indulges in long periods of petting is merely expressing his devotion to her. Selfish motives guide him . . . therefore he is doing wrong.

Any time sex passion begins to dominate reason a person is incapable of following the unselfish intentions he has, and it is time for him to get control of himself.

If it becomes evident that a couple going steady aren't suited to each other, it is unselfish for one of them to break the relationship. This should be no reason for them to cease being friends. Unfortunately, hurt pride and jealousy often bring about ill will between the two after they break up.

If a boy is really interested in the welfare of a girl he won't resent her finding someone better suited to her than he is, or vice versa.

Engagements are not irrevocable

The next stage of the boy-girl relationship is the engagement. The engaged couple are almost sure that they are meant for each other, but they are still in a trial period. One's responsibility for the happiness of a fiancé is even greater than that for a steady date and includes the responsibility of breaking the engagement if this seems to be best for either.

Once a couple feel intense devotion for each other and feel that their lives would be incomplete without each other they should begin planning marriage.

Their engagement should be long enough to make sure that the feeling isn't temporary, however, and their activities together should be stripped of part of the glamour of earlier courting so that they may be sure that their personalities are compatible during everyday living as well as on dress-up occasions.

Individual differences

The problem of compatibility of interests and likes loses much of its difficulty if both are unselfish persons. A large part of the problem is already solved.

*The first date—
a good time
and a chance
to learn about
each other.*



An unselfish husband or wife will yield to his spouse's whims concerning minor matters and be the happier for it. On the other hand, two selfish persons are invariably incompatible with each other because it is impossible for two persons to agree on absolutely everything, and if neither is willing to yield, conflict is inevitable.

Only major differences in interests and inborn attitudes cannot be overcome by an unselfish couple, but the less serious the differences the less the strength of character and self-denial required to adjust them. Some differences are almost impossible to reconcile.

For example, a man who couldn't be well-adjusted, satisfied and cheerful living in a city couldn't give much happiness to a girl who had an aversion to living in the country.

And the giving of happiness should be the aim of marriage. Once a man decides to marry a girl he should resolve, "I'm going to make her the happiest girl in the world." And the girl who marries a man should make her primary purpose in life the furthering of his happiness.

Only after marriage

After the couple are married, and not until then, their relationship may virtuously include sexual intercourse. This won't be virtuous, however, unless it is participated in with an unselfish attitude. The man who participates in the sex act with his wife merely for his own satisfaction and with no regard for her feelings and pleasure is being just as unvirtuous as the unmarried boy who "goes all the way" with his date.

It isn't possible for premarital intercourse to take place because of unselfish motives. A person who participates in the sex act should consider before his own pleasure the satisfaction and welfare of the other

participant and the welfare of any offspring which might result from the action. This necessarily limits sexual intercourse to married couples.

A boy seduces his girl friend to satisfy his sex desires and his ego. And the girl yields because of selfish desire for popularity, thrills and experience, or to "catch her man," but seldom, if ever, because of unselfish devotion to the boy. Happiness can never result from selfish action of this kind.

This outline I have given of virtuous relationships between the sexes is very incomplete. I have mentioned only a few of the basic problems which always arise in boy-girl relationships. The problems which young people encounter in their dating and mating are legion and many are peculiar to individual relationships.

But I have given a general picture of the type of virtuous living which I believe could solve all our problems concerning sex morality. I believe that nothing else could do it.

Sex education is no panacea

For example, I won't go along with those who believe that universal sex education is all we need. Sex education, like any other kind of education, doesn't give people good intentions. Virtuous people can use education as a valuable tool for doing good . . . unvirtuous people can use it just as effectively for doing bad.

I think we should have sex education to end confusion and ignorance about sexual matters. But we cannot expect it to solve all our sex morality problems.

When a person reaches the age when the question—what is right and what is wrong concerning relations with the opposite sex?—becomes all-important, he (or she) shouldn't be led to believe that any actions within certain ill-defined limits are all right regardless of the motives behind them.

*To further
each other's
happiness.*



Freedom to choose

He should be led to realize that all selfish actions are wrong and that only unselfish, Golden-Rule actions are right. Then it is up to him to choose what he will do. No one can force him to do right. But he has a sound basis for judging what is right and what is wrong.

A VENEREAL DISEASE STORY



St. Louis finds and treats the infected

by Wilbur D. Akers and John J. Hayes

The operation of an efficient venereal disease program in a metropolitan area the size of St. Louis, Mo., requires a well-trained staff and effective coordination of the program's various phases.

Our staff includes a venereal disease control officer, a full-time clinician, two half-time clinicians, a public health representative, an educator-interviewer, two full-time nurses, a rotating nurse, a technician, three venereal disease investigators and 15 clerks. We work under the overall supervision of St. Louis's health commissioner, Dr. J. Earl Smith.

Our program has six parts . . . education, interviewing, contact investigation, diagnosis, treatment and follow-up. The more carefully we integrate these six operations, the more effectively we function.

Education

In education, we use many media. At the present time we're engaged in a poster campaign calling for the preparation and distribution of four new posters a year. They are displayed in taverns, hotels and cafes in areas where venereal disease incidence is greatest.

In designing the posters we have tried to get away from the stereotypes of the past and to establish a more personal relationship between the poster and those who see it.

One of our investigators works with the Missouri Social Hygiene Association on a film project. He shows films in taverns and churches to any

group that shows the slightest bit of interest in venereal disease. On the assumption that one picture equals 10,000 words, we feel this type of education is effective from the long-range standpoint.

A great deal of venereal disease education is carried on in our diagnostic clinic. We discuss with every person diagnosed as a case of venereal disease the method of transmission, the symptoms, his diagnosis and treatment, and the effects of untreated syphilis and gonorrhea. This conversation is carried on individually and privately and is very well received by the infected individuals.

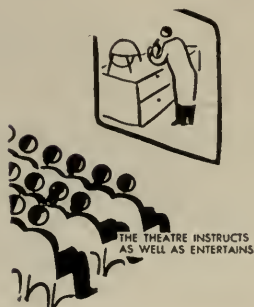
In the knowledge that no one type of education will reach all social groups, we are constantly striving toward a generalized program which will awaken all segments of St. Louis's population to the VD problem.

Interviewing

We are also constantly looking for the most effective case-finding techniques. We have tried multi-test and mass blood-testing programs in areas of high incidence and have been comparatively effective in discovering cases. But the expense is relatively great, considering the number of new cases discovered.

Our experience—like the experience of others—has shown that the least expensive and most productive method of case-finding is the interviewing of all diagnosed cases of venereal disease to get the names of their sex contacts during the infectious period of the disease.

Our venereal disease interviewer has been trained in a United States Public Health Service school, one of the two such schools located at Alto, Ga., and Norfolk, Va. In a two-week specialized course, students are taught by well-trained Public Health Service personnel to develop productive interviewing techniques. Successful completion of this training does not necessarily produce a successful interviewer, of course, for the schools can only place the tools for interviewing in the hands of the potential interviewer. He must then experiment and supplement his training with broad experience.



*A film showing
for any interested group.*



STRIKE OUT!

Remember . . .

You may have Syphilis and not know . . . only a blood test can tell! Go to your doctor or come to the Health Dept. Clinic . . . Room 18 Municipal Courts Bldg. 14th. and Market Streets.

SYPHILIS IN ST. LOUIS

CARDINALS HOME GAMES

APRIL		JULY (Cont.)	
15*, 16*, 17	Pittsburgh	5*, 6	Pittsburgh
26*, 27, 28*	Chicago	10*, 11*, 12	Philadelphia
29*, 30*	Brooklyn	13, 14*	Brooklyn
		15*, 16*, 17*	New York
		18*, 19*, 20	Boston
MAY		AUGUST	
1*, 2*, 3	Philadelphia	13*, 14*, 15*	Pittsburgh
4*, 5*	Boston	16*, 17	Cincinnati
6*, 7*, 8	New York	19*, 20*, 21*	Boston
9*, 10*, 11	Cincinnati	22*, 23	New York
JUNE		24, 25*, 26*	Brooklyn
1 (2), 2*	Boston	27*, 28*	Philadelphia
3*, 4*, 5*	Philadelphia		
6*, 7*, 8	Brooklyn	SEPTEMBER	
9*, 10*, 11*, 12	Cincinnati	3*, 4*	Chicago
		5*, 6*, 7	Pittsburgh
JULY		23*, 24*, 25*	Cincinnati
1*, 2*	Cincinnati	26*, 27*, 28	Chicago
3*, 4 (2)	Chicago		

*Indicates Night Games

BROWNS HOME GAMES

APRIL		JULY	
18, 19, 20 (2)	Chicago	22*, 23*, 24*	Philadelphia
22*, 23*	Cleveland	25*, 26, 27 (2)	Boston
24*	Detroit	29*, 30*, 31*	Washington
MAY		AUGUST	
13*, 14*, 15*	Philadelphia	1*, 2, 3 (2)	New York
16*, 17	Boston	5*, 6*	Detroit
18 (2)	New York	8*, 9*, 10 (2)	Cleveland
20*, 21*, 22*	Washington	11*, 12	Chicago
23*, 24, 25 (2)	Cleveland	30*, 31 (2)	Detroit
26*, 27*, 28*	Chicago		
30 (2)	Detroit	SEPTEMBER	
JUNE		1 (2)	Cleveland
14, 15 (2)	Philadelphia	9*, 10*	New York
17*, 18*, 19	Boston	12*	Washington
20*, 21, 22 (2)	Washington	14 (2)	Philadelphia
23*, 24*, 25	New York	16*, 17	Boston
26*, 27*, 28*, 29 (2)	Detroit	20*, 21 (2)	Chicago

*Indicates Night Games

It can't miss with baseball fans.

Persuasion and persistence

The interview is frequently a contest between patient and interviewer. In many cases, the patient will attempt to withhold information about some of his sexual exposures, or give false information. The interviewer's training and experience enable him to know when this situation arises and how to cope with it. It is equally important not to trap the patient in a lie, as it will make him more reluctant about giving the information.

From many interesting experiences our interviewer chooses two examples to demonstrate some of his interviewing problems:

A 19-year-old boy was diagnosed as a case of secondary syphilis, probably infected within the last six months. The interviewer explained the situation to the patient, tried to win his confidence and started the interview:

"When was the last time you had sexual relations with a girl?"

"About nine months ago."

"How many girls have you had since then?"

"Haven't had any."

"Are you sure? Do you realize their health is in your hands?"

"No sir, the last girl I had was nine months ago. If I didn't catch it from her, I don't know where I got it."

"The stage of your disease indicates you caught it in the last six months. That's all there is to it."

The patient didn't seem to be lying and yet we knew the infection was contracted within the last six months.

The interviewer then asked, "When was the last time you had sexual relations with a fellow?"

"Can you catch syphilis from another man?"

"You certainly can."

"Well, I had sexual relations with two different fellows in the last four months."

After gathering the information on the two contacts the interviewer asked, "Now you realize the importance of not overlooking anyone—for those you overlook may be the ones that are infected. Think carefully. Have you had any other fellows?"

"Oh, yes, there's one more man I had about three months ago."

We investigated his three homosexual contacts, and on examination found two of them to be infected. One of these two named four additional homosexual exposures. There is little doubt that we will discover additional cases in this chain of infection.

She conquers her pride

Recently a 60-year-old woman came to the clinic. The tests showed she had syphilis . . . in a late stage.

Since she was the mother of nine living children, in the interview we set out to get their names and addresses. The interview went as follows:

"Did you ever have any idea you might be infected with syphilis?"

"No, is that what I have?"

"Yes, and you probably have been infected for quite some time. Chances are you may have passed syphilis to your children when you were carrying them."

"Is that the same disease that you get from foolin' around?"

"Yes, it is, but it's known as congenital syphilis. We want to examine your children to find out if any of them are infected."

"Well, I won't tell you anything. I don't want them to know."

"Do you realize some of them may be infected and not know?"

"They're not infected. They've always been healthy."

"That's beside the point. They can have syphilis for many years and feel fine until it's too late to help them."

Silence from the patient.

"I certainly wouldn't want my mother to be selfish and think only of herself. Why should they suffer for something they aren't responsible for?"

At this point the patient indicated she was weakening and would eventually name her children . . . but not without some more pressure.

"You realize that syphilis can be the reason for death. Do you want to be responsible for that possibility?"

"Certainly not. No mother would."

"You're placing their health in jeopardy by not having them examined."

With this the patient took a different attitude and named all her children. They are now being investigated.

Interviewing is an art . . . the entire results of case-finding are dependent upon the validity of the information produced in the interview.

Investigation

Investigation is the backbone of our control program. The word investigation carries a ring of glamour, but there's very little glamour attached to the actual work. It's a difficult and thankless task that constantly calls for tact and resourcefulness on the part of the investigator, to cope with the changing situation.

As we've said, we interview all VD cases to learn the names of their sex contacts during the suspected infectious period. It's the investigator's

job to *locate* those contacts. In many cases the information is very scanty and may include only a description, not a name.

When he finds the contact, the investigator must reveal to the contact the facts of the exposure without divulging the source of his information. Next the investigator must make sure that the contact is examined either by a private physician or a health department clinician. If he is examined prior to the end of the suspected infectious period, in the case of syphilis the contact must have blood tests every month until that period has expired.

Some difficulties

The investigator faces all kinds of problems every day. He must cope with reluctant proprietors of places of exposure who do not understand his purpose, with inadequate information on contacts, with skepticism on the part of the contact, and with a shifting population in areas of high VD incidence.

The following case occurred during the war years and was extremely interesting as it exemplifies some of the daily experience of our venereal disease investigators:

A 35-year-old woman was picked up by the police in a tavern raid. A routine blood test indicated she was infected with syphilis.

The woman was interviewed for sexual exposures and named her husband. The address she gave was a fake, and our investigator was temporarily stymied.

At this point he talked to the woman again and got additional information. Her husband was attending a local school of pharmacy. The man was located in a school and his correct address obtained.

Upon calling on him the investigator identified himself and received a most cordial welcome. He was invited in. The wife was there and it was difficult to avoid recognition of her.

The investigator explained the situation, and the husband became very angry. The conversation went as follows:

"You have no right coming here. I should throw you down the stairs."

"You wouldn't want to hurt me, would you?"

At this point the husband started going through some bureau drawers. The investigator feared the search would produce a gun. But the husband came up with a medical book and commenced reading it.

"You needn't read any more. I'm not a doctor and I don't understand it. All I want to know is—are you going to accept the appointment to come to the clinic for examination?"



Missouri-born of a family partial to teaching. After a long career in selling, attended St. Louis University and USPHS interviewing schools. Has been a VD investigator 10 years.

Wilbur D. Akers

"No, get out of here."

With this the investigator left and by coincidence met a sergeant from the Morality Squad. (A few years ago we used the police in our uncooperative cases, but we have since tried to eliminate use of the police in venereal disease control whenever possible.) The investigator told his experience to the sergeant and together they went back.

The husband made the mistake of going through the bureau drawers again, and the sergeant did not wait any longer to act. He apprehended the man and jailed him for examination at the VD clinic. The examination showed he was infected, and we carried out the treatment. Throughout our entire association with him he was troublesome.

Peripheral problems

A venereal disease investigator's job does not stop in venereal disease control. He serves as liaison between the public and the clinic. His actions in the field reflect not only on himself, but on the Venereal Disease Control Service and—most important—on all divisions of the health department. He is constantly looking for other public health problems. When he finds one, he reports it to the appropriate section of the health department.

This teamwork is exemplified in the following incident: A few days before Christmas in 1949 an investigator was checking a patient who had lapsed from treatment. The patient's wife, when she was asked where her husband was, replied, "He's out selling our boy's bicycle to get some money for food." The worker was then invited in to wait for the husband.

*Treatment and follow-up
to find those who don't
respond to therapy.*



*His wife had syphilis.
He wasn't interested.*



He noticed two infants in the room, both coughing and running a fever. Assuming from past experience that these children were in need of immediate medical care, the investigator returned to his office and summoned a nurse to the home. The nurse at once recognized that the children were ill and hospitalized them immediately.

This was not the end of the story. One of the newspapers picked up the story and tied the human interest angle to the Christmas season. This produced a flood of food, toys and money to the family.

This happy outcome is solely attributed to the alertness of a venereal disease investigator who felt his job did not stop with the locating of the suspect.

Treatment and follow-up

The ultimate purpose of venereal disease education and case-finding is to bring the infected to treatment and to routine serologic and spinal follow-up examination.

St. Louis is fortunate in having adequate treatment facilities to accommodate any part of its population without embarrassment or loss of working time by the individual. Our facilities include the City Diagnostic Clinic, Midwestern Medical Center, Firmin Desloge Hospital Clinic, Homer G. Phillips Hospital Clinic, Washington University Clinic and, most important, many family physicians. Without private physicians to diagnose and treat patients, the incidence of venereal disease would multiply to a point where the health department would be unable to manage with our existing facilities.



*U. S. Navy and Coast Guard veteran
with 67 months' service in VD control.
Formerly a USPHS VD investigator
and an educator-interviewer for the
St. Louis VD Control Service.
Now a University of Missouri student.*

John J. Hayes

Because of today's rapid penicillin therapy syphilis can be cured in a very short time. Treatment in the cooperating clinics is free and simplified in order to inconvenience the patient as little as possible.

Since patients differ in their reaction to therapy, it is necessary to carry on post-treatment follow-up schedules. This is done to determine as soon as possible which patients did not respond to the therapy. When such cases are discovered—they are the exception rather than the rule—they are evaluated and retreated if additional therapy is indicated.

If these cases were not discovered they might become afflicted with one of VD's many late complications, thus becoming a burden to their families or wards of the community. Consequently, it is wise economics, as well as good for the patient, to carry on this follow-up.

Treatment and follow-up are different throughout the city, but essentially they conform to the recommendations of the U. S. Public Health Service.

Summary

The VD staff worker needs a stout heart, broad sympathy, and genuine interest in people—plus training in technique. He must get the cooperation of many of his fellow citizens to reach the right people in the right places in the right way. He must be able to draw from them the facts he needs to locate contacts. He must have the patient, endurance and persuasiveness to convince these people that they may need treatment. Dramatic his work sometimes is, but it is the day-to-day routine, shared in by loyal clerks behind the scenes, that finally brings the victim of VD to the clinic and thus back to good health.

CREDITS

Photo courtesy Haga, Minneapolis, Minn., p. 342.

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Photo courtesy Australian News and Information Bureau, p. 347.

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Photo courtesy National Urban League, p. 367.



Military + Civilian = Control

VD Control in a Military Area

by Sidney S. Lee, M.D.

Eighteen months ago Camp Lejeune, the marines' training base in North Carolina, had the questionable distinction of possessing one of the highest VD rates among naval installations in the United States.

And this despite the fact that within the camp itself a VD control office was in operation. Lt. Robert Graham of the Navy, assisted by Douglas McAllister of the Public Health Service, was conducting an intensive troop education program. As a result, Camp Lejeune marines are now probably as well informed about VD as any other military group in the country.

But at that time it was apparent that a concerted effort on the part of civilian as well as military authorities was needed if we were to succeed in lowering the VD rate.

For those of you who are unfamiliar with the Camp Lejeune area, I should like to describe it briefly in order to place the VD problem in proper focus. Picture an area in southeast North Carolina, flat as a billiard-table, stretching 75 miles along the coast and 20 to 40 miles inland . . . about the size of Delaware. Near the northern end of this coastal plain is Camp Lejeune. It occupies about 160 square miles—

and has an average military population of 35,000 marines. It is the largest general marine training base in the U. S.

A few miles from the camp is Jacksonville, N. C., a military boomtown with an estimated population of 18,000. It is a rather poorly organized community with some of the worst housing problems in the nation.

About 50 miles to the south and west lies Wilmington, the nearest large community. It has a population of 55,000 and numerous defense industries, and is growing rapidly.

Between Jacksonville and Wilmington stretch 50 miles of sand, sparsely populated, with small farms and no industry.

The total non-military population of the entire area is approximately 140,000, roughly 25% Negro.

People on the move

The most outstanding characteristic of the area—military and non-military—is the extreme mobility of the population.

- Marines on week-end passes travel as far afield as Boston, Chicago and Jacksonville, Fla.

- During the summer the beach resorts bring an enormous influx of population of a highly transient nature, difficult to locate and inaccessible to ordinary channels of health education.

- Large construction gangs are housed in temporary facilities near the marine base and in Wilmington. Their homes are in several neighboring states as well as throughout North Carolina. On week-ends, the construction workers usually go home.

- Married marines, who live all along the coastline and as far as 65 miles inland, commute daily to the base.

- Seasonal farm and fishing labor groups move in and out of the area. The large fertilizer industry, also seasonal, employs about 1,500 men.

- Wilmington is a growing seaport with merchant seamen and Coast Guard personnel entering and leaving the area.

- In addition, the peripatetic group of waitresses and ever-present camp-followers—as well as Florida-bound tourists—may be added to our group of transients.

New Hanover County, of which Wilmington is the county seat, has a well-organized and adequately staffed health department. However, Onslow County, in which Camp Lejeune is located, and Pender County, just south of that, share one minimally-staffed district health department.

Graduate of Yale's school of science and school of medicine. Until June, 1952, VD control officer for the Camp Lejeune area. Now acting director of VD control for West Virginia's health department.

Sidney S. Lee, M.D.



Where were the cases?

Initial assessment of the VD problem in the area revealed an apparent contradiction of the well-established dictum that military VD rates reflect VD rates in the surrounding civilian population. Onslow County reported very little VD . . . 20 cases per 100,000 per month. Pender County reported no VD cases. However, New Hanover County was operating a VD clinic and reported three cases of syphilis per 100,000 per month and about 100 cases of gonorrhea (160 per 100,000) per month.

As we shall see, there was no dearth of VD cases in Onslow and Pender counties, but merely an inadequate case-finding program.

Three basic needs

It was obvious from the first that there were three basic needs:

- Establishment of good clinic facilities for the treatment of cases within these counties (we felt that we would only hamper defense efforts if large numbers of patients were dispatched to the rapid treatment center).
- Inauguration of intensive case-finding activities.
- Development of a VD education program for the civilian population.

The first step in clinic development was the reorganization of the VD clinic in Wilmington. Records—136,000 separate pieces of paper—were reviewed and four-fifths of them were discarded as useless. Physical facilities were rearranged to permit easier handling of patients. Treatment and follow-up schedules and interview procedures were revised.

Facilitation of handling of patients in the clinics made clinic attendance more attractive. This, coupled with increased contact investigation, produced a doubling of the case load within the first month.

A stepped-up program in Onslow County

After a similar review of Onslow County's records, a separate VD clinic was established there. It was then decided to have an intensive educational campaign and serological survey in that county. Cooperation

of civic authorities, local practitioners, newspapers and radio was secured. The local radio station ran daily 15-minute transcriptions and six daily spot announcements for six weeks.

Through the cooperation of the camp, a sound-truck and the services of two marines were obtained. The marine camp prepared large signs for our "Fight Syphilis" campaign.

Negro teachers helped with clerical work. The Negro high school football team ran miles throughout the countryside, knocking on doors and urging people to come to our film showings.

During October and early November we made about 2,000 blood tests, with an overall positivity rate of 10.9%. Most of these were made in Negro churches which cooperated in sponsoring film showings. More than 800 of 1,200 employees of a huge military housing project submitted to blood-testing on the job. In all, about one-fourth of the Negro population of the county was tested.

During and following the survey, attendance at the Onslow County clinic increased considerably . . . 20 to 25 patients were seen at each clinic session. All patients were interviewed for contacts, and appropriate follow-up was instituted.

A faster laboratory test

Through the cooperation of the Venereal Disease Research Laboratory, a training course was held for laboratory technicians from Camp Lejeune, Jacksonville, local hospitals and the Wilmington health department's laboratory. Technicians were trained to perform the quantitative VDRL slide test in place of the various qualitative tests they had been doing.

Conversion of laboratories to this test has permitted us to have quantitative results within 24 hours. (Specimens sent to the state laboratory and the rapid treatment center usually required considerably more time.) This change aided immeasurably in bringing cases rapidly to diagnosis and treatment.

Notices of conversion of testing procedures were sent to all private physicians and clinics. Small hospitals and physicians in the area were encouraged to perform routine serologies on all patients. Physicians with industrial practices were asked to do blood tests as part of pre-employment examinations. As a result, the total number of serologies done in the community has increased steadily, with a concomitant increase in cases found.

Rapport with private physicians

The availability of health department records and consultative services was emphasized in our approach to the private doctors. In a letter we told physicians of our willingness to do spinal punctures, process spinal

*One-fifth
of the Negro
population
was tested.*



fluid and send reports within 48 hours. In personal conferences we encouraged physicians to report cases and contacts.

At present a day rarely goes by in which we do not have at least one call from a physician for consultation, for investigative work, for performing a spinal puncture, or for planning treatment and follow-up. Our activities in this direction have resulted in improved relations between private physicians and the health department.

When our program started, about 10% of all patients treated in the Wilmington clinic reported previous attempts at treatment in drugstores. It was necessary to use vigorous measures to discourage this practice.

We waited until we got a good case—an 18-year-old boy with lympho-granuloma, huge buboes, penile ulcers and a profuse gonorrheal discharge. He had been treated for two weeks with salve in a local drugstore. We put him into a car, took him to the drugstore, invited the person in charge into the back room, showed him the lesions, and asked if he had any further recommendations for therapy. Following this, a letter was sent to all druggists requesting their cooperation.

This rather radical approach has almost eliminated treatment of VD in drugstores.

The problem of VD among high school students was acute in Wilmington. During three weeks in November of 1951, 21 high school students were named as contacts, some of them repeatedly.

We therefore arranged a series of meetings and encouraged the establishment of a Negro Community VD Committee with membership consisting of parents, the Negro newspaper publisher, a lawyer, a representative of the juvenile court, two ministers, two recreation workers, and a representative of the housing projects. At a meeting of the high school PTA, films were shown and leaflets distributed. This group of about 150 parents and teachers pledged its support.

With the help of the juvenile court, a meeting of parents of those students named as contacts was held in the courtroom. Following the showing of the film "Feeling All Right," we discussed with these parents the nature and seriousness of the VD problem and solicited their help.

Since that time only three high school contacts have been named.

Tavern and restaurant operators

Periodic meetings are held with all restaurant and tavern owners, hotel and bus station operators. Special meetings are held for operators from whose establishments two or more contacts have been named in a three-month period. Speakers at the meetings include a representative of the juvenile court, a food sanitarian, a state malt beverage control officer, representatives of the disciplinary control board from Camp Lejeune, and VD control workers.

At these meetings, we show films and distribute leaflets. The operators learn of our desire to achieve cooperation and of the possible penalties of non-cooperation.

Through an understanding of their role in community responsibility for VD control and through active measures on their part, contact reports from all of these places of business have shown a marked downward trend. Operators now assist our VD investigators in locating contacts and distribute VD leaflets in their places of business.



*Migrant farm workers
are part of our
shifting population.*

*The private physician
assisted in raising
treatment standards.*



Industrial workers, too

Through the cooperation of the State Board of Health's industrial hygiene division, a mobile chest x-ray unit was assigned to the area for a two-week period for an industrial survey. Approximately 2700 x-rays and 1250 blood tests were performed . . . we did blood-testing only in selected industrial groups. Excellent cooperation was obtained from the plant managements and personnel. The overall positivity rate for this group was 17%.

All of these cases have been evaluated and given necessary treatment. Their contacts have been investigated.

Each morning we examine all new prisoners in the county jail. About 10% are usually found to have syphilis or gonorrhea. We have made arrangements with the judge and solicitor to provide for treatment of all those found to be infected.

Examination of food-handlers has been a well-developed tradition in Wilmington. Most newspaper advertisements for employment specify that domestic servants as well as employees of food-handling establishments must have a card from the health department. Approximately 400 of these examinations are performed monthly.

No delays in contact reporting

In our area there are four investigators—one in the camp and three in the counties. They have proved to be invaluable.

One of their problems was delay in obtaining contact data. Ordinarily a contact report moves from one county to another—via the State Board of Health—in from 7 to 10 days. Since most of the contacts we reported lived in adjacent counties, we decided to speed the contact data to our area's investigators by sending it to them direct, in advance of the

routine report via the State Board of Health, on yellow, unnumbered epidemiology report forms. With this speed-up, contacts are usually located and brought to treatment within 48 hours after the information is obtained.

This has proved to be an extremely effective administrative procedure, and has served to limit the spread of infection.

Personal contact and exchange of information among all personnel involved in VD control in the Camp Lejeune area have also improved our operations. Military interviewers from the camp visit in Wilmington and Jacksonville and learn the sources of their contacts and the difficulties in investigation. Interviewers from the counties visit the camp periodically.

As a result, more accurate and detailed contact reports produce more effective investigations. Participation of our staff in meetings of the disciplinary control board of the camp and in area-wide conferences has proved valuable in planning.

Much has been done

I have attempted to give you a brief summary of some of our activities during six months of operation of a VD control program in the Camp Lejeune area. It is, of course, too early to evaluate our program statistically.

But a good many improvements are already making themselves apparent.

- The clinics themselves are being operated more efficiently.
- The reservoir of infection is steadily diminishing.
- Whereas 50% of the military's VD contacts were from within our area two months ago, less than 10% are from our area at present.
- The assistance we render to private physicians is helping to raise the standard of medical care in the community.
- In addition, our program has not only made the population VD-conscious (and health-conscious), but has also proved to be an effective tool for improving relations between the health department and the community.

We have found that a VD control program must be adapted to the nature of the population. The cooperation in our area has far surpassed what we expected, but much remains to be done. VD control still represents an enormous challenge.

BOOK NOTES

by Elizabeth B. McQuaid

Any Wife or Any Husband, by Joan Malleson. New York, Random House, 1952. 237p. \$2.75.

The two parts of this book, respectively titled "Introduction to Sexual Difficulties" and "Details of Sexual Difficulties," might make it appear to be technical and pathological. Actually it is a sound and sane book which may be read easily by anyone of ordinary education, and which deserves wide circulation. It originated in England, where Dr. Malleson (herself a mother and a grandmother) is well known as an obstetrician and a leader in the birth control movement. She discusses all the common sexual adjustments and adaptations that a young couple will be likely to encounter. Throughout she insists that these problems are usually of educational or emotional character—not due to any peculiarities of anatomy or physiology. Indeed, she admits that in many instances a well-trained lay marriage counselor can do more for them than the average physician. But the purpose of the book is to enable any wife or any husband to avoid or remove obstacles to happy marriage.

Paul Popenoe

American Institute of Family Relations



Marriage and the Jewish Tradition, edited by Stanley R. Brav. New York, Philosophical Library, 1951. 218p. \$3.75.

This volume gives some insight into the nature of the Jewish tradition which has long understood the function and role of the home as a stabilizing factor in society. The approach of the book is neither anthropological nor sociological but is designed to be a guide for modern living based on the insights and truths evolved by Judaism. In this regard the book succeeds admirably, although one could wish that more of basic Jewish information were included.

Rabbi Brav has collected a number of essays by outstanding Jewish leaders and thinkers who have given much thought to the marital situation within the Jewish framework. Whether or not the contributions by Felix Adler or Louis Wirth are germane is a matter of interpretation alone. Some further thought, however, might have been given to a necessary chapter on divorce and a more scientific appraisal of sex in Judaism.

Neither of these two subjects has been handled adequately within the confines of this work.

The Jewish family tradition was based and still is founded on the reverence for life. It was this basic feeling and attitude which made of the Jewish family a strong, close-knit group which could withstand many assaults upon its integrity. In this fundamental attitude sex was seldom, if ever, regarded as sinful but part of the gifts of life which man must learn to use wisely and creatively. Marriage is a holy relationship, sanctified by God and man. Holiness is linked to reverence and in these integral perspectives Judaism consolidated family life into a profound human experience. The various authors—Cronbach, Baeck, Buber, Weinstein and the editor—amplify these ideas in most readable and moving essays.

Rabbi Albert A. Goldman
Temple Emanu-El, Yonkers, N. Y.



Community Planning for Human Services, by Bradley Buell and associates.
New York, Columbia University Press, 1952. 464p. \$5.50.

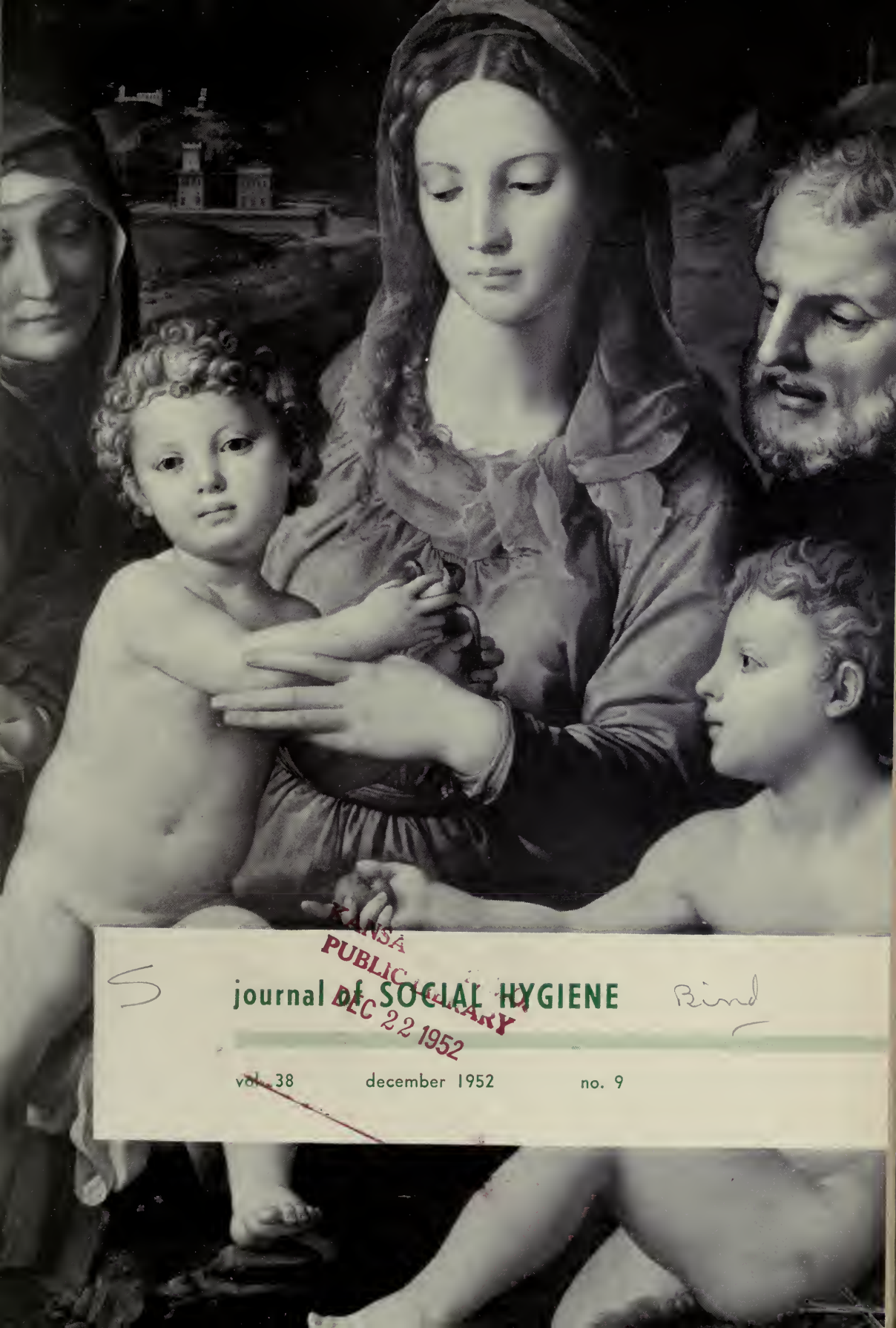
This volume presents documentative facts which open new, integrated approaches to age-old problems in community services. The authors believe that we know better than we do—for community planning.

The basic research concludes a study of the community set-up of 108 service agencies of St. Paul, Minn. This project of more than three years was underwritten by the Grant Foundation and conducted by the staff of Community Research Associates, of New York City, under the direction of Bradley Buell.

Surveyed on a family basis, the four major problems—dependency, ill-health, maladjustment and recreational needs—converge to absorb the vast services of St. Paul's agencies for a small percent of the population. The authors have spotlighted the nature of family living not only to show how one serious problem involves the lives of the entire family, but also to show how that same powerful family unity can be a vital asset in a coordinated program. Students and workers in social and mental hygiene will agree with the approach to human needs from babyhood to old age.

Community Planning for Human Services is worthy of what it was meant to be—resource material for those “who wish to do a more purposeful job of planning for the common welfare.” The extensive bibliography, footnotes and index make it a book for public and professional libraries.

Gertrude Daniel
Board of Education, New Brunswick, N. J.



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vol. 38

december 1952

no. 9

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About our cover . . .

Die Heilige Familie, by Bronzino. Eighteenth of a series of Journal covers on family life . . . photograph courtesy of the Kunsthistorisches Museum, Vienna.

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THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association, published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922. Copyright, 1952. American Social Hygiene Association. Title Registered, U. S. Patent Office.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association. Subscription price: \$3.00 per year. Single copy: 35¢.

*YD officer during World War I.
Then head of the National Health Council.
Later director of health and sanitation
for the Office of Inter-American Affairs.
Now a regional representative for ASHA.*

Thomas C. Edwards



Social protection — a workable plan

by Thomas C. Edwards

Most people want to live and raise their children in wholesome surroundings.

Some of them realize that a community which tolerates commercialized prostitution attracts other forms of vice. These informed people also know that corruption inevitably accompanies prostitution, and that law enforcement against more serious crimes almost invariably breaks down wherever prostitution exists.

Then there are many civic-minded people who don't condone commercialized prostitution, but simply put up with it . . . if it doesn't try to move into their neighborhood.

Still others—even more misguided—nurture the idea that a wide-open town helps business. They like to think that prostitution is here to stay, and that nothing can be done about it.

But a great deal has been done. It's true the millennium hasn't been reached. But if you look at the record there's conclusive evidence on hand to prove that conditions at the end of 1952 are a lot better than those which existed 40 years ago in many American cities.

The force of public opinion

It's been a rough, tough fight these last 40 years. Today it's much easier to fight the prostitution racket. Practically every state now has laws against most phases of commercialized prostitution.

But laws don't enforce themselves. Enlightened public opinion is a powerful auxiliary weapon for the civic-minded who want to eliminate conditions endangering health and moral welfare. These citizens must make sure that their public officials perform their sworn duty to enforce *all* laws . . . whether they are in sympathy with those laws or not.

One should never forget that a community receives just as much law enforcement against commercialized prostitution as its citizens demand.

Those who claim that prostitution has existed since time began and always will should be told to advocate the repeal of all prostitution legislation. How many would stand up and be counted?

From our long experience we know that most law enforcement officials will institute a vigorous campaign against prostitution activities if they have the backing of citizens.

The citizen in a key position

There are many ways in which you can cooperate with the officials you elect. Here are a few of your responsibilities . . .

- Report to the police those you suspect are identified with the racket.
- Develop and support social services which will work with your public officials by caring for those cases which are beyond the available facilities provided by the city and county governments.
- Reduce your community's crime potential by providing character guidance activities—youth councils, classes on marriage and parenthood, adequate recreation facilities—designed to guide young people in the right direction.

This adds up to good social hygiene . . . which has been defined as “our efforts to *prevent* the illness, unhappiness and tragedy growing out of venereal disease, prostitution and promiscuity. Social hygiene is *prevention*—right training in childhood and youth to achieve right thinking and conduct in maturity. Social hygiene stands as the philosophy and method by which we can generate much of the world's happiness and vigor.”



To develop understanding — family life classes.

ASHA's pioneer program

So far, no better means of driving towards that goal have been proposed than the balanced four-fold plan outlined by the American Social Hygiene Association's founders:

- *Medical and public health measures*—to prevent, to cure and at last to eradicate the venereal diseases.
- *Legal and social protection measures*—to wipe out prostitution as an organized business, and to prevent sex delinquency and promiscuity.
- *Educational measures*—to teach the right and highest use of sex in life, as a base and bulwark for the kind of character we need on which to build and maintain family life which insures community growth and national security.
- *Public information and community action*—to energize the other three parts of the social hygiene job, and merge the whole into a steady, active operation.

The second of these goals—legal and social protection measures—has five components:

- Adequate state laws and city ordinances
- Active police
- Understanding courts
- Adequate places of detention giving maximum attention to rehabilitation
- Voluntary agencies helping to return offenders to useful life

As to the first, many states have adequate laws against prostitution. Others could make their laws considerably more effective.

The police and public opinion

My experience with police departments in many communities of all sizes and in all parts of the country convinces me that when the police understand that citizens want effective law enforcement, the police provide it. Where trouble exists in any great proportion it rises more from the citizens' lack of desire for a clean community than from the police department's lack of know-how.

If the police resist public pressure, as they have done in a few instances, communities can clean up only after a grand jury has thoroughly investigated the situation and recommended removal of the recalcitrant officials.

Harassing the procurer

Even then the job isn't done. Constant vigilance is necessary. Exploiters of all descriptions must be ferreted out and eliminated by one legal means or another, for they are the ones responsible for most of the prostitution that exists.

We can have compassion for the girl or woman who is involved, but for the individual who exploits her we can feel only the greatest contempt. Most often, this go-between is a porter, bellboy, cabdriver or hotel clerk.

If constant raids and the placing of uniformed police officers at the entrance or in the lobby of offending establishments are ineffective, the use of the injunction and abatement law is successful. Most property owners will evict tenants when they realize that injunction and abatement proceedings may publicize their names and padlock their property.



*Prostitution, corruption,
weakened law enforcement—
an inevitable progression.*

Closing the houses

A fact proved many times over is that the closing of brothels does not multiply other kinds of prostitution—neither the streetwalker nor the tavern B-girl. But the closing of brothels does mean that these decentralized operators still require the utmost vigilance on the part of the police.

Over and over again, outstanding police officials point out that to shunt girls across the city limits—and this is still being done in some places—is to make a problem for some good neighboring community and for themselves, because this good neighbor may simply shunt the girls back.

Just to fine and release or jail offenders for short periods is to start the cycle again and to make more work and expense in the future, probably only days later. The American Social Hygiene Association refers to these methods as the revolving-door system. Every means at hand should be employed to break up this vicious circle.

If the police will report to the health department the names of all individuals apprehended on charges of prostitution or promiscuity, the police will thereby greatly help the fight against VD. While it isn't a crime to have VD, those who are infected must be found and treated . . . and treatment is the responsibility of the health department, not of the police nor the court.

Policing hang-outs

Amusement places, hotels, tourist camps, dancehalls, restaurants, bus stations and taxicabs are often favorite hang-outs of prostitutes. Until they feel community pressure and positive police action, tawdry, semi-underworld places and people, unscrupulous juke joints and unsavory hotels will not mend their ways. Not only are they hang-outs for confirmed prostitutes and procurers . . . they are cradles of delinquency for young girls.

In a number of cities, operators of hotels, taverns and taxicabs have set up very effective methods of self-policing with strict rules for the conduct of their employees as well as their customers. The chief problem is not with the better places but with the dissolute spots requiring special police surveillance.

Through careful selection of employees, adequate pay and close supervision, hotels, taverns and cab companies cut down markedly the chances that their employees will resort to procuring prostitutes for customers. On the other hand, where minors of both sexes receive substandard wages, where late hours are necessary and where poor moral conditions exist, promiscuity and prostitution have an open field.

A helping hand for the police

The police have a difficult and incessant job on their hands, and it is hard to find a police chief that will admit having sufficient manpower and womanpower to cope completely with the situation. It is therefore still more important that we citizens help out.

It is not easy to overemphasize the importance of the part grand juries, district attorneys, sheriffs and state and county police can take in the repression of prostitution and promiscuity. In some communities the mere fact that grand juries are in or about to go into session has caused prostitution racketeers to curtail or cease operations entirely. These juries have been of inestimable assistance in forcing clean-ups in communities whose law enforcement officials could not bring them about. In many localities where the local police could not or would not do the job themselves, district attorneys, with the aid of the state police, have been responsible for a complete clean-up.

Such activities usually strengthen the desire for a wholesome community among citizens who had only a casual interest before . . . and often bring about the replacement of complacent officials with more conscientious successors. In short, a live-wire prosecutor can just about control a bad situation if he is so minded.

Sheriffs, county and state police must be relied on to keep the neighborhoods beyond city limits free of prostitution.

*We can develop private agencies
to rehabilitate the offender.*



Court procedure

An excellent statement by the New York Welfare Council sums up a number of the outstanding requirements for sound court procedure in prostitution cases:

- All cases in which women or girls are involved as sex offenders or victims of sex offenses should be concentrated in one court . . . a women's court, if possible. However, if a juvenile court exists, it should handle cases against young girls.

- A limited number of judges, carefully chosen, should be permanently assigned to these courts.

- The judges should draft a code of procedure requiring: a calendar that won't allow lawyers to maneuver their cases before a certain judge; an orderly atmosphere, including registration of visitors to discourage curiosity-seekers; cubicles in which lawyers can talk privately to their clients; entrances kept clear of hangers-on; and a time-limit on the trial of women out on bail so they can't resort to prostitution to pay their lawyers and bondsmen.

- In large cities, a record should be kept of prostitution cases handled by any given lawyer in any year, to indicate organized forces back of the prostitutes. Competent legal service should be available to all women so that they won't find themselves in the hands of those who will exploit them.

- Similarly, lawyers should furnish sworn statements on fees, dates due and source of payment, and defendants should file sworn statements on the source of bail. This helps expose the "system."

- Judges and probation departments should work out a simplified form on which to enter such facts as the defendant's age, family resources, earning capacity, previous history and psychiatric reports if available.

- Sentences should be uniform, and probation should be used when advisable.

- Suspended sentences and short-term commitments should be wholly eliminated. Probation or commitment to institutions offering rehabilitation programs should replace them.

- Judges should consult and plan with probation authorities and heads of institutions for individual cases which give promise of genuine rehabilitation.

The girl delinquent

The fight against delinquency is probably of top priority in any social protection program. A girl's initial offense—depending upon the way the police handle it—may be a determining factor in her life. A girl who is just a stray pick-up today may become a hardened prostitute or she may become a good member of the community and lead a happy life, depending upon how she is handled by the law enforcement people and other community agencies.

In this effort the qualified policewoman is most successful. But an average police officer, if he is interested and knows about community

*Court calendars
can prevent
a judge's
monopoly
on prostitution
cases.*



resources, can do a good job. A thorough study of the girl's case and wise recommendations have a strong bearing on her future.

For instance, the child welfare department or a private agency may take care of her. The juvenile court may be used. Her family may be instructed to take over, provided, of course, they are a desirable influence. Detention may still be the answer. I refer here only to early treatment situations, where there is hope of nipping the trouble in the bud.

What is a policewoman?

Too much stress can't be put on the part a trained or qualified policewoman can play in this unhappy drama. But it isn't easy to get a properly trained and experienced woman for the job.

She should have better than average education, good health, social work experience and psychiatric training. She should be attractive, well-adjusted, emotionally mature and level-headed. She must be willing to learn all there is to know about the control of delinquents, and feel a keen interest in this important humanitarian vocation.

Her primary responsibility should be to spot young people in dangerous situations. Her ability to make innumerable friendly contacts with hotel and rooming-house managers, bus and railroad station attendants, bus and truck drivers will determine her success. As soon as these contacts realize she is trying to *help*, there is no end to the cooperation she will receive.

She must constantly inspect places of amusement, taverns and dance-halls as well as bus and railroad stations where girls—especially stray girls and out-of-towners—are apt to show up. Her friendliness, that big-sister sort of approach, is most convincing.

Above all, she should prove her value to her brother officers and win their cooperation and help.



*A live-wire
district attorney
can stimulate
a listless
police force.*

Detention facilities

Here is a short list of policies regarding detention facilities and places of incarceration that was prepared by the Federal Security Agency in cooperation with a number of law enforcement officers:

- Minimum attainable goals for adult and juvenile detention should be agreed upon, and law enforcement officers should then work toward their attainment.
- Law enforcement officers should recognize that while they are responsible for the administration of jails and lockups in most areas, they do not have the responsibility for determining the kind of facility to be provided. Close cooperation with county and city fiscal and administrative authorities is therefore indicated, to the end that proper facilities may be established.
- Pending the establishment of adequate jail systems, law enforcement officers should devote their energies to bringing about standards of cleanliness and sanitation to make health and decency possible for the inmates. They can at least make certain that prisoners do not actually have their health impaired.
- Proper methods of segregation can keep apart inmates who might be harmed, physically or morally, by contact with others. Jails should not be "schools of crime."
- The worst features of enforced idleness should be eliminated through the constructive use of inmates' time.
- People with a legal or moral right to be held elsewhere should never be detained in jail. These people include juveniles, the insane, the feeble-

minded, chronic alcoholics, and anyone who—regardless of ability to raise bail—is a good risk to remain in the community under pledge to appear when required in court.

- The fee system (a per capita amount provided to jails for the maintenance of prisoners) should be discontinued.

Juveniles should not be held in custody any longer than absolutely necessary, especially while awaiting court action. An effort should be made to work out with their parents or guardians a guarantee that they will be kept out of trouble while awaiting the court's decision.

In some communities specially operated detention facilities or subsidized foster homes are available. Travelers Aid and other private agencies can be tremendously helpful in maintaining a constant list of such homes.

If young sex offenders must be incarcerated, their chances for rehabilitation will depend upon the kind of institutions to which they are committed. These should be as near ideal as possible.

When offenders are released, community organizations have their biggest opportunity to be of real service . . . by finding homes for them (or in helping them to adjust to the limitations of their own homes) and by finding jobs for them.

Three basic forces

In any community there are three basic forces which should work together to eliminate prostitution and other vices:

- Active and persistent public agencies such as police, courts, detention facilities, probation, public welfare, health and other services.

- Volunteer groups such as social hygiene societies or committees, health associations, social welfare agencies, Travelers Aid, PTA, church groups and family service associations.

- The general public, whose job is two-fold—to elect good officials and to support and maintain volunteer groups.

Back to the home

Social protection is a tremendously important part of any well-rounded community program for social hygiene. Like most other aspects of life, social protection begins in the home, with a proper and happy family life. For it is in the family that we should get the first precepts of lawful and correct living, and it is to the family that we must look for cooperation in the rehabilitation of those the family fails.

HAVE YOU . . .

Renewed your ASHA membership for 1953?

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An Artist Diagnoses Sex Offenders

by Priscilla B. Reed

*Foreword by Miriam Van Waters, superintendent,
Massachusetts Reformatory for Women*

The diagnosis and treatment of sex offenders is one of the tasks of those who rely upon the social hygiene movement to help build a worthy civilization.

While only a fraction of the total number of sex offenders are committed to correctional institutions, in a reformatory for women they represent about 80% of the population under sentence.

What is done for them? Unless there is understanding of their emotional life, no fundamental treatment is possible.

At the Reformatory for Women in Framingham we use a variety of methods to get responses which will reveal the inner hurts, fears, anxieties and conflicts of those committed to us. Psychiatry, psychology, religious counseling, group therapy and psychodrama are employed—anything to elicit self-expression.

These methods are often successful. They show us that underneath the presented problem of larceny or assault there is likely to be a sex problem . . . and underneath the sex problem there is likely to be a childhood terror or other form of suffering.

Mrs. Reed's article offers a new approach, for she is an artist with rare psychological insights and intuition. Her present method of diagnosis of emotional conflict has been used about two years now, with three years' previous therapy work leading into the present method in our reformatory.

The results are important for all those who wish to know more about human behavior and the relief of suffering, both in children and adults.

Art therapy—what is it?

The following is a descriptive case study of work being carried on in a new projective technique proposed for use with female delinquents. It bears no similarity to either the Rorschach (or, as it is more commonly known, "ink-blot") test nor to the thematic apperception test. It is not possible at present to make reproductions of color plates used in this test.

Priscilla B. Reed, who does diagnostic work at the Massachusetts Reformatory for Women, is a Graduate of Abbot Academy, the University of Maine and the School of the Museum of Fine Arts, Boston.

because the original plates are not yet copyrighted and the author-designer is the only one possessing them.

Before these color plates were designed as aids in personality diagnosis, I had carried on diagnostic work through the drawings, paintings and small ceramic pieces of a limited number of girls who could come for "art as therapy" in the Massachusetts State Reformatory for Women. These came at their own request or were assigned by the superintendent.

By its very nature the work was slow and limited. We needed to find a method by which designs of diagnostic value could be presented to a larger number of women, many of whom would never be entering the "studio" for work of their own.

New entrants at the reformatory, preferably those whose case histories and psychometrics are unknown, take the test. This gives the examiner an opportunity to make her analysis without prejudice or bias, and serves as a real trial for this process, which is still in its experimental stages.

15 plates

Out of the 40-odd plates originally made, only 15 are still in use. In selecting the 15 we had the help of a practicing psychiatrist, and kept in mind the instructions of research psychologists to achieve a three-fold purpose:

- A minimum of content in the structure
- Progression of color intensity
- Progression of psychological intensity

The project is based on human emotions . . . each subject is asked to express *her feelings* on seeing the plate presented to her. The "seeing" is secondary to the "feeling." A control group, established at a nearby teachers' college, helps to establish the validity of the project as a whole.

Mary—a new inmate

A frightened, pale young woman in the blue dress of the reformatory's receiving section sat before me. Her fingernails were badly bitten. Nervously she glanced about the room, which is furnished with my personal belongings, including books and pictures. It is a large, light, airy and quiet place, removed from the bustle likely to be found in other parts of the building.

This was her first commitment and she was discovering that all sorts and kinds of things happened during the first three weeks. She had been examined physically and mentally . . . and she had been interviewed—by kindly people, but strangers nonetheless—and now here was something else in this informal living-room. Was this woman before her some sort of officer too?

Her first day

The day of her arrival at the reformatory was an indistinct blur. She could remember weeping on the clean, narrow white bed in the small room to which she had been assigned after the receiving officer had asked her to bathe, hand over her clothes and belongings, and put on one of the plain blue dresses she now wore.

At first trays were brought to her room, and she couldn't eat in the small, pleasant dining-room with other people until certain physical checks had been made. Her tears had fallen onto those food trays, but now she felt a little stronger and a little less bewildered.

She felt nothing

Now there was a sort of numbness in her feelings. The woman across the card-table from her seemed to be giving directions in a quiet way. She tried to listen, but her mind wandered.

The woman was asking her to express what she felt about each plate that she would see. How could she do this when she had no feelings at all? What did the lady mean?

As the first plate was handed to her, Mary asked, "How do you mean, *feel*?" The lady merely repeated much of what she had said before.

To Mary this plate she held in her hands was sort of a picture but there seemed to be so little in it. Suddenly the situation began to seem serious, although the lady smiled at her. Embarrassed, Mary felt the tears starting from her eyes as she hastily said, "It's a lonesome road to travel alone."

The lady had been taking notes, Mary couldn't imagine of what . . . now she saw the lady writing what she had said, only there seemed to be more. (There *was* more. The examiner must not only note the subject's verbal responses, but all her gestures as well. It is in large measure for this reason that the tape-recorder has been ruled out as an aid.)

Without realizing it, Mary squirmed in her chair. There was something terribly hard about all this, yet she wasn't sure why. She didn't like to cry, yet somehow she felt so close to it.

She couldn't say that

The lady held up the second plate a minute before passing it to her. Mary *thought*, "How queer, what a strange thing!" She *said*, "People

dancing.” She *thought*, “They look naked, but I can’t say that. It wouldn’t be nice. And how do I know they’re people? They look like other things too.” (And why did the lady keep writing all the time when she had said hardly anything?)

And so it went on. It seemed as if the plates became harder and harder. She was getting tired. What difference did it make what she said about them? She’d say any old thing that came to her head. The lady was encouraging. Somebody was nuts around here, and she was sure she wasn’t, in spite of all the drinking.

Her father

Why was it she was reminded of all her troubles now? On that last plate—why did she say what she did? There was no picture of her father there . . . but suddenly she had thought of the night he came into her room whispering, “Sh!” and got into bed with her. She could never tell her mother what he did, but ever since she had felt dirty and ashamed and it didn’t matter what became of her.

There was a little blood on the sheet which she had to quickly wash off before her mother saw it . . . this plate she was looking at seemed to be bloody. Oh, my! She suddenly realized that she had not said anything to the lady for a long time, but she seemed to be writing just the same. Rape was strongly in her mind, but she couldn’t say it was her father, so she quickly improvised a first boy friend.

Mary began to cry. I handed her some Kleenex. She asked for another cigarette and I lit it for her. She was ready to go on with the series. I had made notes on her traumatic sexual experience, and by devious responses to other plates, she was revealing a fairly complete personality picture in the realm of feelings, or emotions. An allied difficulty was her drinking because she “was lonely” (rejected), and she “felt ashamed to be lonely.” Her husband was “mean” to her, “stayed home just long enough to get her pregnant.”

*Her husband had been
her first boy friend.*





*How many questions
in how many interviews!*

Her husband

Mary felt both mad and sad about her husband . . . but there was the shadow of an old guilt gnawing at her. She *said*, "My father gave me everything I wanted, pretty things. I was his favorite." She *thought*, "He gave me pretty things but he ruined me. I never dared tell my husband, and I've always wondered if he knew I had had relations with someone before I met him. He was my first boy friend."

The reader must here realize that although traumatic sexual experience is seldom discussed in public, many people have known it but have somehow in the course of existence managed to circumvent their difficulty, which doesn't, of course, always take the form Mary's did. But incest occurs more commonly than the average person realizes.

Don't for a moment think that Mary's problem was typical of all women who come to the reformatory. In *her* case, her deepest problems lay in this particular area—her father's incest when she first came into puberty. In another person the emphasis would be on some other topic.

A synthesis

Like diamonds, human problems and their relation to the society in which we live have many facets, and the one is seldom the answer to all. No one response to any single plate in the test series creates the total picture in the final comment the examiner makes when the test is over and the Marys long since have returned to their rooms.

At the classification conference table, the case worker reviews the case report, both the court record and the woman's story. I hear the medical report and the psychometric findings.

I listen carefully and a bit nervously—as would anyone working on an experimental project—for my intuitive findings concerning Mary and her problems may be all off. To date they have not been off, but have

either confirmed material given by other workers or have added to the diagnostic profile which the superintendent needs before recommending treatment.

The emotionally sick

My present project works from one angle alone—the human emotions.

Emotionally sick people are everywhere, as testified by ever-increasing world unrest and ever-enlarging mental hospital populations, and it is disturbed personalities—frequently asocial—that we see in our penal institutions. Part of this prevalence is the direct result of an era that considered emotions inferior, unworthy things, something to be suppressed . . . because tears are a disgrace, laughter often out of place, and temper not to be tolerated.

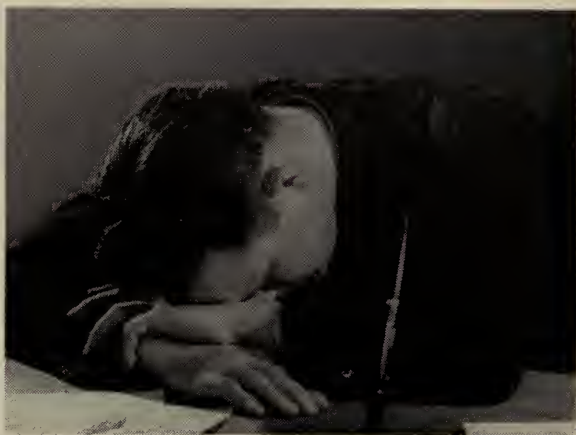
As an artist I am deeply concerned with these attitudes. Since a truly functioning artist must have well-developed emotions, he is likely to be actively conscious of the emotional responses of others.

In Mary's case, we saw her confusion when she tried to express her feelings about the color plates she saw. Emotionally associative factors were at work in her which made her have frightening memories.

Wisdom plus heart

As a summary, I'd like to quote from James Stephens' *The Crock of Gold* a conversation between two philosophers: "To understand the theory which underlies all things is not sufficient wisdom may not be the end of everything. Goodness and kindness are, perhaps, beyond wisdom. Wisdom is all head and no heart. Behold, brother, you are being crushed under the weight of your head. You are dying of old age while you are yet a child."

*Emotions
can get
out of hand.*





How do city people think about VD?

Columbus, Ohio, interviews 990

by John A. Morsell, Ph.D.

In the October 20, 1950, issue of Public Health Reports Dr. Joseph W. Mountin, assistant surgeon-general of the United States Public Health Service, referred to the progress achieved in a quarter-century of venereal disease control when he observed, "We are reaching the point, in fact, where it is possible to speak not only of syphilis control but of the eradication of syphilis."

With this extension of horizons, workers in the field have recognized the need for re-examination and possible revision of their methods and procedures. In this spirit, the Public Health Service's venereal disease division, the Ohio Department of Health and the Columbus, Ohio, health department cooperated with Columbia University's Bureau of Applied Social Research in two studies of the social psychology of venereal disease. Their primary purpose was to obtain information which would aid in more effective application of education to venereal disease case-finding problems.

Here are some of the suggestive findings dealing with public knowledge and opinions of venereal disease. Other findings, dealing with the factors which motivate infected people to volunteer for diagnosis, will be reported in a later number of the Journal of Social Hygiene.

What does the public know?

Although we know the American public has information about venereal disease, we don't know exactly the quality of this information or how it varies among different social groups. Accordingly, the community study with which this paper deals was set up:

- To provide systematic data on the knowledge, interest and attitudes of people in the general population with respect to venereal disease.
- To ascertain the effectiveness of educational measures designed to mold these factors.

The study should be viewed as a single case history. The proportions of people possessing varying degrees of knowledge and different kinds of attitudes are established for Columbus only and may differ in other communities, just as the rate of infection is not the same everywhere. But the elements that make up public opinion and their relationships—the influence of venereal disease *knowledge* on venereal disease *attitudes*, for instance—should have more than local significance.

Area sampling

The method of area sampling, which insured that every member of the Columbus population within the desired age range (18 to 45) had the same chance to be selected, was used to seek 1,000 interviews (actually 990 were obtained) with a representative sample of Columbus residents.

Following this and according to deliberate plan the Community Health Council—in cooperation with state, county and city health agencies—staged a comprehensive publicity and educational program in Columbus. Immediately afterward, a second wave of 1,017 interviews was obtained, on the same basis as the previous one and therefore equally representative of the community. The second group of respondents was interviewed in the same manner as the first, with the addition of certain questions specifically designed to cover the reception of the campaign materials.

Here is our analysis of their knowledge and opinion about venereal disease. Except as noted, the data reported here are those secured from the precampaign sample of 990 interviews.

The level of knowledge

Syphilis and, to a slightly lesser extent, gonorrhea appear to be familiar diseases to the average citizen of Columbus.

When asked whether they had ever heard of these two terms, all but 11 of the 990 respondents expressed familiarity with the term syphilis and all but 63 had heard of the term gonorrhea. Some of those who didn't know the medical terms were familiar with colloquial names for these diseases. Taking this into account, only six people (less than 1%) showed unfamiliarity with syphilis, and only 33 (3%) were not familiar with gonorrhea.

They didn't know the symptoms

Familiarity with the term syphilis, however, is not necessarily associated with any given degree of accurate knowledge about its origins, symptoms and course of development.

Twenty-two percent (somewhat more Negroes than whites) said they didn't know "what troubles or symptoms people usually have when they get syphilis." Moreover, by no means all those who professed to have this information were actually correct in what they said. Among the answers given spontaneously to the question, sores and rash predominated, but there were frequent references to such alleged symptoms as drip, discharge, swollen ankles, fever and general debility. When questioned specifically about each of these in turn, the percentages of people naming sores and rash as syphilis symptoms increased greatly, but there were similar increases in the percentages identifying drip, discharge and swollen ankles.

The proportions among whites and Negroes in these respects were very much alike, although the latter tended again to be less correctly informed. This indicates the continued importance of information about symptoms as part of the venereal disease message.

Symptoms and contagion

Only 65% of the respondents were sufficiently informed to know that the signs and symptoms of syphilis may sometimes be absent or imperceptible. Asked whether one "can give syphilis and not have any signs or symptoms," 14% believed that this was not possible and 21% said that they didn't know. (In this instance, the Negro and white percentages were the same.)

It is reasonable to regard correct knowledge on this point as an important element in a person's alertness to possible infection . . . it seems to need continued, and even expanded, emphasis in the venereal disease educational program.

"Innocent" methods of contracting VD

People's notions regarding the origin of syphilis were explored by the question: "How do people get syphilis?"

The most common answer was, of course, sexual intercourse (given by 76% of whites and 68% of Negroes). But anywhere from 20% to 40% of respondents also mentioned eating or drinking utensils, toilet seats, kissing, non-sexual social contacts, and the congenital route, roughly in that order. (It is, of course, true that syphilis *can* be contracted through non-sexual channels, however infrequent this may be.)

A sizable proportion (three-fifths) of those who failed to mention sexual intercourse at all as a route for infection didn't mention it even when asked: "How do *most* people get syphilis?" This kind of response comes from two types of people:

- Those who apparently are genuinely unaware that syphilis is usually contracted in sexual intercourse.
- Those who are unwilling to acknowledge this source.

This finding suggests that material dealing with non-sexual sources must be carefully presented so that information about the "harmless" or "innocent" modes of acquisition will not supplant or block the recognition that sexual intercourse is the most frequent one.

Attitudes toward venereal disease

The Columbus questionnaire contained a series of questions—general at first but increasingly specific and personal—which sought to disclose the basic attitudes of the respondents toward venereal disease, and toward syphilis in particular.

From queries such as "Why do *people* avoid treatment?" or "Why are *they* afraid others might find out?" to those seeking the respondent's own personal reaction ("Would *you* be afraid others might find out? Why is that?"), the interview probed along the lines of possible guilt feeling, expectations about the reactions of friends, fears about the future in case of infection, and the like.

The answers to these various attitude-questions made it possible to describe a respondent's sentiments toward venereal disease in two ways:

- With respect to the kind of conception, or *image*, he had of syphilis.
- With regard to the degree of *anxiety* he experienced in connection with syphilis.

The image of syphilis

People's feelings about syphilis were found to fall into one or another of three general patterns. In one image, people viewed syphilis primarily as a problem of *individual, personal well-being*. They voiced concern over the physical accompaniments of the disease, such as its unpleasant and painful symptoms, the pain suffered in treatment, its debilitating physical and mental effects if not treated in time.

A second image took its root in the sources of infection. People defined syphilis as a *moral* problem that reflected upon the "sinfulness" or "shamefulness" of the presumed circumstances under which it was contracted.

In a third pattern, the attribute of contagiousness was predominant. Here respondents considered syphilis as a *social*, interpersonal problem, in which they considered the infected person not only a threat to other, and perhaps innocent, people (such as a spouse or children), but also to his friends, who would therefore avoid contact with him. In this conception, syphilis meant social isolation or a deficient sense of social responsibility.

They fear social and moral stigma

Very few respondents expressed only one of these patterns of attitude toward syphilis . . . all three notions were widespread and appeared in the majority of interviews. The average person's image of syphilis may thus



*Why do people
avoid treatment?*

(Posed by model.)

be said to be multidimensional. Herein seems to lie one of the major difficulties of syphilis control, especially as regards volunteering for diagnosis.

A great number of those interviewed clearly considered syphilis a serious disease, and no member of the sample believed that if untreated it might "go away again." Not everyone, of course, has the kind of knowledge which would lead to a suspicion of venereal disease in case of infection . . . people need to know that the disease can be successfully treated (35% of the sample considered syphilis "very hard to cure").

But aside from these factors related to adequate information, the belief that infection will invite social isolation and moral condemnation almost certainly hampers the acknowledgment of infection.

Thus, 50% of the respondents gave shame as their reaction to the possibility that other people might find out that they were being treated for syphilis. Another 5% would be ashamed unless it could be made plain to everyone that they had caught the disease "innocently."

Only 15% replied that they just wouldn't be concerned about public opinion because "all I'd care about is to get healthy." Twenty-seven percent of the cases showed concern for public opinion, but they quickly added that they would "face it" and get treatment anyway.

Fears divorced from knowledge

It seems likely—although it cannot be established by the data of this study—that a person who would fear the discovery that he was being treated for syphilis would be somewhat hesitant about seeking treatment. Although it is true that the respondents in this survey were merely discussing a hypothetical situation, the cure motive might gain in strength if the people were actually infected and suffering from symptoms of the disease.

Also, one should bear in mind that those who are most likely to become infected appear to be less firmly bound by convention (and hence less

sensitive to moral disapproval) than a cross-section of the population such as contained in our sample. But even if the responses we've just discussed don't warrant a prediction of behavior in case of an infection, they do reveal the existence of motives which are essentially in conflict with straight health interests.

Furthermore, these fears, like most of the other attitudes examined in the study, are apparently unaffected by the amount of knowledge which people possess. Differences in knowledge about venereal disease were found to have little or no relation to their opinions about venereal disease.

Syphilis and extramarital relations

Even prior to infection, health concerns which might lead people to take precautions against acquiring VD are not considered of major importance.

The second wave of interviews included two questions aimed at discovering whether fear of catching the disease tended to deter people from illicit sexual relations. Asked to select the most important of several reasons why people do *not* have sex relations outside of marriage, only 29% named fear of syphilis as the most important. (The other reasons were fear of pregnancy, fear of ruining one's chances for marriage, and sinfulness.)

Given the possibility that a way could be found to vaccinate people against syphilis (as with smallpox), only half of the respondents thought that such a vaccination would affect the amount of extramarital sex relations . . . the others stated largely that they didn't think people were "that much worried about catching syphilis."

To summarize the survey findings, while the average citizen of Columbus was convinced that syphilis is dangerous to health, he did not consider this fact a major reason for avoiding possible infectious intercourse, nor did he necessarily consider it the strongest of the many factors likely to affect an individual's course of action *after* contracting an infection.

The level of anxiety about venereal disease

It is apparent from this description of the various ideas about syphilis that people hold that they differ in the intensity of their concern regarding it. Some of them are worried about it. Some are "afraid" of it. Some would feel "guilty" if they found out they had syphilis.

In an attempt to gauge the degree of anxiety, answers to the attitude-questions were rated according to how much "emotion" they appeared to reveal. While only 11% of the respondents expressed attitudes entirely free from worry, the proportion who showed real anxiety ("emotional" reactions to more than half the questions) was relatively small also—25%. The majority of the sample gave a moderate number of responses denoting anxiety.

The low average level of anxiety displayed in Columbus makes it understandable why most people do not consider fear of catching syphilis the



*The younger you are
when you learn about VD,
the more you know.*

most important reason for avoiding extramarital sex relations. On the other hand, it seems to be a degree of worry which is consistent with the statement made by 75% that if infected they "would feel careless or stupid for not having taken precaution."

In other words, the average person seems sufficiently worried by the detrimental effects of VD infections upon his health, social status and personal relations that he can be induced to be careful . . . but apparently he is not so afraid that he would be inclined to live differently.

In addition to knowledge, conceptions and degree of anxiety regarding syphilis, a fourth major area of public opinion was investigated. This is the extent to which the average person accepts syphilis as possibly significant for himself personally. While the degree of identification may be related to what a person will actually do in the event of infection, this cannot be determined from the data at hand. What can be learned is whether the degree of identification is likely to affect the amount of venereal disease educational material people receive.

It is well known that those reached by a particular kind of educational message are likely to be those already interested in the topic. (Radio programs devoted to tolerance toward minority groups, for example, tend to reach members of the minority groups or those who already have a tolerant attitude. Political campaign speeches tend to be heard by those politically interested, and particularly by those in favor of the speaker's point of view.) Audience-building then becomes a major part of the promotional task, in addition to the development of a body of information to which we desire to expose the audience.

It therefore seemed important to discover just how much readiness exists on the part of the general public to think of syphilis as a problem that might apply to them personally.

Personal interest in VD

From the answers to several related questions, it was possible to construct a measure for this psychological readiness and to rate the members of the sample according to it.

By and large, the degree of such readiness was not very high.

- While only a handful showed no inclination at all to concern themselves with syphilis, the majority was grouped along the lower half of the scale.

- The attribute was considerably stronger among men than among women.

- It was somewhat more in evidence among Negro than among white respondents.

- There was more of it among respondents from areas of the city having high syphilis incidence rates than among those from low-incidence areas.

- It was unaffected by differences in the amount of schooling.

Whatever the origins of such psychological readiness, there seems no question that it is important to the VD educator in achieving adequate audience penetration by the mass media of communication he employs.

When respondents were asked whether they would be interested in getting more information about venereal disease, the smallest proportion (57%) expressing such interest was found among those whose readiness was rated low. Among those with average readiness ratings, 65% wanted more information, and among respondents with high readiness ratings, 73% were interested in learning more about venereal disease.

These differences hold up regardless of race or sex. Possibly the people who display a high degree of psychological readiness and who also have the most interest in getting more information are exactly the ones in greatest need of this information. No definite answer could be obtained from the community study, because it was not possible to know who among the respondents was infected or most likely to be infected.

But insofar as VD education aims at educating the general public, it must face the fact that one of every two persons who are not themselves personally concerned with the problem says he doesn't *want* to be educated regarding it.

Response to educational material

One aspect of people's experience with venereal disease educational material is, of course, the way in which it affects their knowledge of venereal disease. Here the Columbus data were clear-cut in only one detail—the age at which the person first obtained his knowledge. Those who had learned before they were 20 were much better informed than those who learned after 20. The finding holds for both sexes and both races, regardless of the present age.

As far as the *sources* of their information were concerned, the differences were so slight that it can't be said any one source contributed substantially more than any other . . . partly because most people learned from a variety of sources and the impact of any one main source was blurred. It also reflects the influence of factors other than the nature of the source on the amount of current knowledge which people possessed.

To an extent at least, extensive penetration to the desired audience is clearly the result of the coverage given a topic. This is illustrated by the Columbus demonstration program, which exposed people to more educational matter in one month than they had been exposed to in the fairly normal preceding period of six months.

Perhaps to an equal extent, the degree of penetration is also determined by the level of interest in the topic and in the themes it introduces.

A medical check-up

The Columbus campaign interested mostly those who were psychologically ready to be concerned with the problem of venereal disease . . . and its most consistent effect was to make those it reached think about their own health or about getting a medical check-up.

The campaign analysis appears to point another particularly important lesson: Members of the sample were asked what further kinds of information, if any, they would like to receive. The preference of the great majority was for information on symptoms and treatment. They expressed relatively little liking for material on prevention (which puts responsibility on the individual) or on consequences (which are frightening).

Yet when they were asked later what themes, if any, had induced them to think of their own health (or of a check-up), the most influential themes were those dealing with the consequences of untreated syphilis.

This experience is paralleled by similar results in the realm of commercial advertising, which has also had to develop techniques for the



*Most respondents
showed little anxiety
in answering questions.*



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most effective handling of themes which are distasteful or which appeal to fear. The method usually followed is the scare-solution approach, which couples the fear element with the promise of a solution . . . in this case, treatment plus cure. The Columbus campaign did use a scare-solution approach, and the results it achieved were related to this basic method.

A final implication, based on an overall consideration of the survey findings, is that general public concern with the VD problem can be most readily stimulated by careful emphasis on the contagiousness of syphilis—what we have referred to earlier as the social image of the disease. This has the advantage of suiting those whose main concern is the health aspect as well as those who conceive of syphilis as a problem of immorality.

This interpersonal reference coincides with the normal human desire to avoid responsibility for infection and to think of syphilis as something that one “catches,” yet it does not encourage the passive-victim frame of mind or a concentration on the “innocent” sources of infection like eating utensils or toilets.

It seems unlikely, at least so far as this study indicates, that VD educational campaigns will soon have much success in inducing people to change the conduct of their private lives. But stress on the dreadful consequences avoided by early treatment, and on contagiousness, which is the problem of the infected as well as of the uninfected person, should help to bring about some increase in preventive behavior as well as more of the desired voluntary action on the part of those who become infected.

Summary

This paper has reviewed some of the findings of a survey of popular knowledge and opinion regarding the venereal diseases based on 990 interviews in Columbus, Ohio. It indicates some of the lessons venereal disease educators may derive from this survey and from the evaluation of a comprehensive educational campaign conducted in connection with the survey.

Can you answer this VD quiz?

Don't look now, but you can find the answers to these questions on page 400 . . .

1. Is syphilis a dangerous disease?
2. Can a person catch syphilis from another person?
3. Is the first sign of syphilis usually a sore?
4. Is syphilis cured when the sore heals?
5. Is a sore the only sign of syphilis?
6. If a sore appears which may be syphilis, is it safe to wait a while before going to the doctor?
7. Does treatment for syphilis take a long time?
8. Is it important to go to a doctor for treatment?
9. Is gonorrhea the same disease as syphilis?
10. Can a person have syphilis and gonorrhea at the same time?
11. Do some people call gonorrhea "the clap," "a dose," "gleet," and "running range"?
12. Is there a gonorrhea sore like the syphilis sore?
13. Does gonorrhea cause trouble if not treated?
14. Can a person catch gonorrhea during sex relations with a person who has it?
15. Do many people have gonorrhea?
16. Can a good doctor cure gonorrhea?
17. Is a reliable doctor the only person who can cure syphilis and gonorrhea?
18. Is it all right to have sex relations when one has syphilis or gonorrhea?
19. Can a person catch VD from utensils, toilets, tools or machines?
20. Is there a way to prevent VD?

Give yourself 5 points for each question you answer right . . .

	YES	NO
NO. 1	<input type="checkbox"/>	<input type="checkbox"/>
NO. 2	<input type="checkbox"/>	<input type="checkbox"/>
NO. 3	<input type="checkbox"/>	<input type="checkbox"/>
NO. 4	<input type="checkbox"/>	<input type="checkbox"/>
NO. 5	<input type="checkbox"/>	<input type="checkbox"/>
NO. 6	<input type="checkbox"/>	<input type="checkbox"/>
NO. 7	<input type="checkbox"/>	<input type="checkbox"/>
NO. 8	<input type="checkbox"/>	<input type="checkbox"/>
NO. 9	<input type="checkbox"/>	<input type="checkbox"/>
NO. 10	<input type="checkbox"/>	<input type="checkbox"/>
NO. 11	<input type="checkbox"/>	<input type="checkbox"/>
NO. 12	<input type="checkbox"/>	<input type="checkbox"/>
NO. 13	<input type="checkbox"/>	<input type="checkbox"/>
NO. 14	<input type="checkbox"/>	<input type="checkbox"/>
NO. 15	<input type="checkbox"/>	<input type="checkbox"/>
NO. 16	<input type="checkbox"/>	<input type="checkbox"/>
NO. 17	<input type="checkbox"/>	<input type="checkbox"/>
NO. 18	<input type="checkbox"/>	<input type="checkbox"/>
NO. 19	<input type="checkbox"/>	<input type="checkbox"/>
NO. 20	<input type="checkbox"/>	<input type="checkbox"/>
SCORE	<hr/> <input type="checkbox"/>	<hr/> <input type="checkbox"/>

A score of 50 is not too good . . . 75 is not too bad. If you scored 100, you're a smart person who knows how to protect yourself and your family from VD.

Here are the right answers . . .

1.
Yes. Syphilis can cause miscarriages, stillbirths, heart disease, strokes, blindness, deafness, insanity, paralysis and death.
2.
Yes. A person can catch syphilis by sex relations and other intimate contacts with a person who has syphilis. If a pregnant woman doesn't receive treatment, she can pass syphilis on to her unborn baby.
3.
Yes. One to eight weeks after the syphilis germs get into the body, a sore *usually* appears at the spot where they entered. Sometimes the sore is so small, or hidden, that it isn't noticed. Sometimes it never appears at all.
4.
No. The germs are still alive. They are carried by the bloodstream to all parts of the body . . . where they can do great damage to the heart, blood vessels, brain, nerves, liver, bones and eyes.
5.
No. Other signs are a skin rash, sores in the mouth and throat, swollen glands, headache, fever, pain in the bones. The hair and eyebrows may fall out. These symptoms may be very mild and disappear even without treatment. But the germs are still in the body.
6.
No. See the doctor at once. He can make a diagnosis and cure syphilis, if you have it, with penicillin.
7.
No. Usually only a few days. The sooner you get penicillin, the sooner you will be well again.
8.
Yes. Only a qualified doctor can cure syphilis. Don't trust quacks and patent medicine ads. They only want your money.
9.
No. Gonorrhea and syphilis are two different diseases. Both are catching. Both are dangerous.
10.
Yes. A person can have both diseases at the same time.
11.
Yes. Usually they are people who don't realize how dangerous gonorrhea is.
12.
No. But a few days after the infection there is usually itching and burning, particularly on urinating. Soon a discharge begins to come from the inflamed organs. Women may not notice the symptoms.
13.
Yes. In a man, gonorrhea may damage important glands and make it impossible for him to become a father. It also causes swollen joints and other painful conditions. In a woman, gonorrhea spreads into the internal sex organs and often makes it impossible for her to have children. It sometimes leads to serious operations. In a newborn baby, gonorrhea can cause blindness if the germs get into the baby's eyes.
14.
Yes. Pick-ups and prostitutes often spread gonorrhea to men who then give it to their wives.
15.
Yes. Many people think they're cured when they're not. Others catch gonorrhea during sex relations with these people who aren't cured. Still others put off going to the doctor or try to treat themselves.
16.
Yes. Usually in a few hours.
17.
Yes. Go to your family doctor. If you have none, ask for help at a hospital or at your health department. Don't go to a druggist for medicine to treat yourself. And don't go to a doctor who advertises.
18.
No. Don't have sex relations or kiss anyone until your doctor says you are not infectious.
19.
No. Syphilis and gonorrhea germs quickly die outside the body. Dead germs don't spread diseases.
20.
Yes. Avoid sex relations outside marriage. Don't take chances with pick-ups, free girls and prostitutes. Good behavior is the best way to prevent VD.

Vistas and limits in teaching family life

by Irene H. Williams

Dilemmas aren't new to teachers, but today's teacher faces one of the most exasperating and frustrating pairs of horns ever to confront any group at any time. On the one hand, she is expected to educate "human beings" not "scholars." Her aim is to develop well-rounded, happy, constructive future citizens, not to teach isolated skills. She may feel "old hat" if she concentrates on the three R's, and a failure if she does not promote each year a roomful of creative, well-adjusted personalities.

On the other hand, her study in the field of human growth tells her that a child's basic personality pattern is the direct product of his home experiences. The Midcentury White House Conference on Children underlines the widespread acceptance of this conviction: "In every talk, in every workshop we came back to a recognition of the importance of family life as the foundation of personality development."

This is a difficult paradox. Theoretically, the teacher is not primarily responsible for the child's ability to establish happy social relationships and constructive learning habits. Practically, she feels pressure to assume the burden of his character formation. Guilt and confusion result.

Readin', writin' and 'rithmetic

Some teachers ignore the whole controversy and go on teaching as they have always taught. Some feel guilty over neglecting the majority of the class in concentrating on a few obviously maladjusted students. Many feel anxious, insecure and groping—unsure of goals and uncertain of results. Most find less reward in their work than they should. Not knowing whether they are therapists or educators, they cannot know how to measure their achievements. Time was when a teacher got real satisfaction out of developing a group of good readers, with legible handwriting, and creditable ability in mathematics and other fundamentals.

Today's teacher does not feel satisfied with such accomplishments alone. She must now ask herself in addition, "How well adjusted is this child's total life? How satisfactory are his relationships? Does his social behavior show growth?" These are hard things to measure. In fact, there are as yet no completely satisfactory tools, practical for use in the classroom situation, which do give accurate measurements of such intangibles.

Only by clarifying her own role in the child's development and by realistically defining her own responsibility and goals can the teacher (or



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anyone) be comfortable in her daily work, and find real satisfaction in her job. What does a child need and what can the conscientious teacher realistically expect of herself in relation to these needs?

What every child needs

For optimum development every child needs (in addition to such desirables as a healthy body and normal mentality) truly loving parents and a home life which steadily provides physical, financial, intellectual, moral, social and emotional security to all family members. Deprivations in any of these areas are likely to result in gaps in the stability of the personality.

However, we have come to know that the most damaging lack of all, perhaps the only lack which leaves permanent scars—is deprivation of emotional needs in infancy and early childhood.

A child needs to be a wanted baby, with parents mature enough and happy enough in themselves to be able to give him the gentle care and attention which gradually create his first sense of trust. As a toddler he needs flexible parents who can permit him to take his first steps (literal and symbolic) towards independence without withdrawing the necessary dependent satisfactions—parents who can let him walk alone when he is ready but will be there to soothe the bumps when he flops unexpectedly.

As he becomes more aware of himself and more sensitive to others, he has increasing need of a home where social relationships are harmonious and affectionate, where his parents like each other and him, where attitudes towards others are warm and generous.

Pliable discipline

In such a home a child is loved for what he is. Normal naughtiness, hostile feelings and a reasonable amount of negative behavior are accepted. Discipline is given, but love is not withdrawn. Mistakes are allowed for, but kindly guidance follows them. Standards are high, and parents “stand for” constructive moral and ethical ideals.

But the expectations are not rigid nor impossible to attain, and they are grounded in an understanding of human frailties as well as human potentialities. The child is allowed to be himself and not a carbon copy of

This outstanding article appeared in the *Hawaii Educational Review* last April and in *Child Welfare* last June. Its theme—that the teacher's role in developing a child's personality must have realistic limits—is so reasonably stated that the *Journal of Social Hygiene* is eager to extend its audience by reprinting the article here with the kind permission of both its previous sponsors.

an exemplary older relative or a remembered Elsie Dinsmore. Individual differences are enjoyed, not deplored.

In such an atmosphere, a child develops security—a good feeling about himself and his own worth. He has confidence in himself and others, freedom to enter into new experiences, and ability to establish positive relations with people. In such an atmosphere a child prepares for school without fear, undisciplined social habits or emotional blocks.

Because his needs have been richly satisfied, he is ready for a new level of experience. His problems in making an adjustment are ordinarily minor and of short duration. He settles down more or less contentedly to the job of getting as much out of school as is possible for him.

This, then, is what the child—every child—needs before he ever comes to school. He needs the security of a normal, happy home during the first five or six years of life, and he needs it more than he will ever need anything again.

The first five years and the teacher

This the teacher cannot give. She may regret that many of her students lack this kind of emotionally secure background, but she should not hold herself accountable for such lacks, nor expect herself to be able to fill them, nor feel that she has failed if she cannot handle every personality problem she encounters.

What can she do then? Revert to the more circumscribed curriculum and concerns of former years? Dismiss as impractical the ideal of “working with the whole child towards a better integrated personality?” Turn all children presenting problems back to the parents, since they, not she, are fundamentally responsible?

With teachers as overburdened as they are, turning to any of these possibilities would be understandable. A more constructive approach, however, would seem to be the delimiting of areas of responsibility and the concentration within a narrower field upon those things which she can do and which she is in a critical position to do.

She knows about people

She should first of all be as familiar as possible with human behavior, with what is desirable and undesirable in family living, with what factors



*Love is
a must
for baby.*

promote healthy growth and what factors inhibit it, what behavior at a given age indicates sound development, and which symptoms spell trouble. She does not need to become a specialist in psychology nor saddle herself with extra “courses” unless her own genuine interests make this rewarding to her.

Mental hygiene experts have pulled together a fascinating body of literature—as fascinating as novels because it is the stuff of which novels are made. Familiarity with this, informal discussions with other teachers or interested friends, seminars such as those being offered in family life education—and most important of all, a continuing curiosity about why people act as they do—will give her sufficient background to look sensitively at the children she teaches.

Patience and understanding

The good teacher has always seen her students as unique individuals, and has tried to increase their security and learning-readiness through kindness, patience and ego-building encouragement. As love is the common denominator of a good parent, so patient understanding is the common denominator of a good educator. This she must never lose.

It is only if this does not bring the desired results that she must look for additional aids. The failure of this approach is one of the signs that something is deeply wrong in a child, and is in itself an aid to diagnosis.

When the teacher is satisfied that she has made every reasonable effort without stimulating the desired response from the child, the chances are that this is not a classroom problem but one having twisted roots in an unhappy home. To become further absorbed in untangling the difficulties herself would be unfair to the rest of her students and unfruitful to the mixed-up child.

Referral is not "shirking"

At this point other resources must be called in. Through whatever channels are employed in the individual school from the principal, school counselor or the division of pupil guidance, referral should be made to an agency which specializes in the treatment of such problems. The teacher who understands enough about children's problems and enough about community resources to initiate referral procedures where they are appropriate makes a tremendous contribution to her students and her community. (If there are still schools where such teachers must feel that they are "shirking" in not following through themselves, we should all do something about it!)

The class situation itself is often used to promote healthy family life and add to the understanding of behavior through informal discussions. It is not necessary to set aside a special hour for family life education.

The perceptive teacher, always on the alert for material which will be interesting and valuable, extends discussions of regular subjects—why

*The relaxed child
in school
is the loved child
at home.*



did little Mary in *The Secret Garden* begin to look prettier after she had made friends with the robin and the gardener? What kind of men were Napoleon and other power-hungry leaders? What lies beneath racial prejudices of Nazism, and underneath strong biases in the people we know?

The occasional lapse

More pointedly, from an informal comment, from literature, or pictures, the teacher picks up leads for discussing the normalcy of hostile feelings, jealousy of brothers and sisters (particularly new babies), occasional feelings of inferiority. It is tremendously reassuring to the over-sensitive child to learn:

- That all parents let off steam once in a while.
- That it is good to let out our feelings at times.
- That discipline does not mean rejection.
- That adults as well as children make mistakes.
- That they are sometimes sorry about them but don't know how to say so.
- That no one is, or should expect to be, "perfect."

Group discussion reassuring to child

In such ways, the classroom becomes truly a living experience, concerned with life and centered on the lives assembled together. In such discussions the relaxed atmosphere is more important than the content. The child's security grows from being free to express himself, from having a kindly adult think his ideas are important, and from learning that other people's feelings are much the same as his.

If any child seems unduly upset or volunteers bizarre ideas, it is wise merely to accept his reaction, redirect the discussion, and earmark the incident for further individual exploration.

The teacher can also work directly with parents, not all of them, but some. The signature on a report card is all the teacher sees of some parents . . . but she can see, learn to enjoy, and acquire skill in working with those who do make overtures or respond to invitations to cooperate.

No need to compete with parents

A basic problem of all of us who work with children is the possibility of over-quick identification with the child. That this attitude is felt, not spoken, does not prevent its getting across to the parent. Nor are we slow to respond to their unexpressed critical attitude towards us.

Too often the parent-teacher conference is marked by mutual defensiveness, and is more concerned with justifying individual roles than in understanding the child. "I don't know why you can't handle him at school, he's no problem at home" or "Nancy's so uncooperative. Do you always give her her own way at home?" Such comments quickly put both parent and teacher on guard . . . they feel their abilities questioned and their integrity threatened.

It is of supreme importance for the teacher to remember that even the most "inadequate" parent is doing the best he can at a given moment. He too had parents, deprivations, lack of love, insecurities. Very often he had unhappy school experiences, and he sees you not as a professional adult interested in his child, but as a threatening symbol of authority and criticism.

He may be twice your age, but if his own school days were traumatic, he becomes emotionally (and unconsciously) a frightened eight-year-old. This would be easier to handle if his inward fears were expressed directly in apprehension. Often, however, they are covered up with belligerence. (How many bond issues for better education have been voted down by taxpayers' unconscious negative feelings about their hickory-stick school days?)

The child is father to the man

If the teacher sees in each problem-parent a troubled human being, and can interpret his truculent attitude as directed not to her but to unfortunate experiences with other "authorities" long ago, she can be sufficiently warm and accepting to make at least a dent in the hostile armor.

One brief conference with a friendly, non-condemning teacher will not revamp a grossly pathological home, but it may make possible better parental cooperation with the school and eventually create a receptive attitude towards desired changes.

*The resistant child
needs
a specialized agency.*





*Worthy father,
worthy son.*

A mother who had been the despair of schools, social agencies and courts because of her marginal home and undisciplined children and who had resisted every approach made to her, was called to school by the teacher of her seriously disturbed son. Expecting the familiar criticism and well equipped to rebuff it, she found herself instead weeping at the teacher's comment, "You must have worried and suffered a lot about Sammy."

She was able to accept referral to a counseling agency and said later that this was the first time anyone had seemed concerned about her, had assumed that she wanted to be a good parent and had suffered because of her failure. Only with this affirmation, and the increased sense of dignity it gave her, was she able to pull herself together and look for appropriate help.

Sugarcoating

A teacher who can approach a parent with liking and sympathy does more than she can ever know or see directly. Nothing is such a "shot in the arm" as encountering, even briefly, someone who likes us and senses sterling virtues in us. The teacher can usually find something for which she can give the parent approval and reassurance. Praise for showing an interest, if nothing else: "It's wonderful when busy parents like you are interested enough to keep in touch with us."

A teacher-parent conference may bring no visible, dramatic changes in a child's adjustment, but if the parent goes home feeling better about

himself (having a better opinion of his worth—feeling more secure), you have, at least temporarily, reduced tension and anxiety in that parent and in the home.

Teachers may forget (thanks to the low pay and heavy demands with which the public rewards them!) that they have a great deal of status. To be talked to as an equal—to have one's opinions elicited by a person with such status, with a reputation for intelligence and learning—is, in itself, an elevating experience for many parents. When this is accompanied by real warmth and humanity a great deal has been given. Then the stage is really set for fruitful discussion of the child with whom both teacher and parent are concerned.

Child feels effect of teamwork

Parents and teachers are the most important influences in a child's life. His security grows when these adults like, respect and trust each other, because his world becomes more stable and trustworthy. People are pulling in the same direction, not at cross purposes. When the child notes differences in the beliefs or methods exemplified at home and school, these can be interpreted as differences, not as wrongs or rights. ("My mother says it's this way" . . . "Yes, many people believe that, but now we are studying another point of view.")

Not all of the job of building vital personalities, happy homes and a free community belongs to the teacher. Parents are still the key figures with major influence upon emotional growth. The teacher can only implement their efforts.

- She does this by preparing herself for her broader responsibilities through awareness of human dynamics and attention to her own mental health.

*It's important to give
the defensive parent,
the belligerent parent,
friendly understanding.*



- She does it with children through the creation of a relaxed, supportive learning situation where usable information about behavior supplements academic skills . . . through perception of children whose problems are too deep for handling in the classroom and making appropriate referrals for help elsewhere.

- She does it by breaking down barriers between parents and schools—seeing parents as people, letting them see her as a human being too—and together engaging in a real partnership for the good of children.

A middle course

Society's demands on the teacher in terms of children's personality development may continue to be unrealistically high. Such demands are the expression of parents' deep anxieties and feelings of failure. It would not be helpful for the teacher to reject this implicit plea for assistance nor to try to do the whole job herself.

She must try to look at the overall problem, decide which areas she can tackle, and then devote her skill and energies where they will be effective. She must not feel apologetic nor guilty about not doing more, for her role is a crucial one . . . and her contribution and reward can be truly great.



BOOK NOTES

by Elizabeth B. McQuaid

Essentials of Public Health, by William P. Shepard, M.D. Philadelphia, J. B. Lippincott Company, 1952. 579p. \$6.50.

The second edition of *Essentials of Public Health* contains a most comprehensive section on the venereal diseases as part of a chapter on "Special Communicable Disease Control."

The objective of the author and his collaborators—"to present the problems, the goals, the rationale and the usual operations of the public health program in brief, simple and readable style"—has been admirably achieved in this lucid description, of value equally to undergraduate medical students, practicing physicians and students of public health and nursing.

In 20 pages one finds described all the essentials of modern VD control, including a short historical sketch of VD control efforts in the United States.

Social hygiene phases of the VD problem are completely discussed. Difficulties peculiar to venereal infections—such as the questions of morality, promiscuity and prostitution—receive appropriate mention.

Community organization for adequate VD control is covered, stressing the activities of the physician as well as the health authority in case-finding, contact-finding, and proper diagnosis and treatment.

This section on venereal disease control embodies the latest information on the subject, and is highly recommended.

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An Annotated Bibliography in Family Life Education, by Marvin Vick, Jr. Jonesboro Heights, Sanford, N. C., North Carolina Family Life Council, 1951. 97p. \$2.00.

For librarians, social workers, counseling agencies and family life educators, this bibliography answers the question, "What books on family life education are available?" Prepared under the direction of the North Carolina Family Life Council, it lists books published in the United States that are currently in print.

In 18 sections—headed for instance, "A Study of Marriage," "Parent-Child Relations," "Family Conflict"—books are arranged alphabetically by author. There is a brief description of content but no evaluation. Related sociological, psychiatric and psychological readings are also included.

Marriage: the Art of Lasting Love, by David H. Mace. New York, Doubleday, 1952. 206p. \$2.75.

The purpose of the book is best stated by the author in the foreword: "I am concerned not so much with the scientific as with the artistic, aesthetic, emotional approach to marriage."

With remarkable fidelity he has unfolded this too much submerged aspect of marriage. Chapter 9, "The Art of Married Love," is the high point and pivot in the development of the theme. The reader is impressed with Dr. Mace's philosophy of life—that all living is an art and is not achieved merely by knowing a number of scientific facts.

So in marriage, knowledge of techniques, skills or the sum of a number of facts does not assure even minimal sexual harmony. Dr. Mace uses clinical material in chapter 19: "She knew just when Harold got to the foot of page 5 and turned over to page 6. It became a routine which habitually ended in failure." Yet there is a wealth of factual data to illustrate how knowledge can contribute to making an art of marriage.

Dr Mace challenges the thought of those looking ahead to marriage as well as those already married. "For the man, love is something he has to give in order to gain the thing he really wants, which is sex. For the woman, sex is something she has to give in order to gain the thing she really wants, which is love." And the only way to know whether you agree with Dr. Mace is to read his exposition of this statement.

It is easy to read, entertaining and very helpful to professional social hygiene workers and to ordinary men and women who might try becoming artists in their mating.

F. G. Scherer, Minister

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H Is for Heroin, by David Hulburt. New York, Doubleday, 1952. 122p. \$1.75.

This is the factual story of 15-year-old Amy Burton, who drifted from marijuana to heroin and in two years became a confirmed dope addict. In that time she lost all the normal interests of young people, failed to get along with her parents, married a dope addict and divorced him, and spent some time in a state correctional institution.

Mr. Hulburt says that although Amy was reticent about her sexual activities, there is little doubt that her crowd of marijuana smokers indulged in a shocking amount of promiscuity, including mass orgies. Heroin users, on the other hand, lose all interest in sex and concentrate their energies on obtaining the drug by fair means or foul. For teenagers inclined to follow the crowd without considering the consequences, this book should serve as an effective "stop sign."

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- ★ To study prostitution conditions, particularly near military installations and industrial centers
- ★ To prepare fully documented reports on local prostitution conditions for the information and guidance of military and civil authorities
- ★ To provide community leaders with the facts about the dangers of commercialized prostitution
- ★ To advise communities on the most effective ways of repressing vice and to recommend ways of treating sexual delinquents
- ★ To stimulate adequate wholesome recreation as a morale-building safeguard against sexual misconduct
- ★ To intensify the spread of sound information about venereal disease, particularly to young people entering the Armed Forces
- ★ To help strengthen family life against the tensions of the times by fighting VD and sexual promiscuity, two major threats to family health and well-being
- ★ To encourage education for family life, through publications, study courses for parents, and formal training for teachers, youth leaders and others who influence young people

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